

(v) Cost period ending date of the second reporting period immediately preceding the cost period in which the charge is to be imposed. The intermediary may request such additional information as it finds necessary with respect to the request.

(c) *Provider charges.*— (1) *Establishing the charges.* If the actual cost incurred (or, if less, the customary charges) in the prior period determined under paragraph (a) of this section exceeds the limits applicable to the pertinent period, the provider may charge the beneficiary to the extent costs in the second preceding cost reporting period (or the equivalent when there is no second preceding period) exceed the current cost limits. (Data from the most recently submitted appropriate cost report will be used in determining the actual cost.) For example, if a limit of \$58 per day is applied to the cost of general routine services for the provider's cost reporting period starting in calendar year 1975 and if the provider's actual general routine cost in the second preceding reporting period, that is, the reporting period starting in calendar year 1973, was \$60 per day, the provider (after first having obtained intermediary validation and subject to the considerations and requirements specified in paragraph (a) of this section) may charge Medicare Part A beneficiaries up to \$2 per day for general routine services.

(2) *Adjusting cost.* Program reimbursement for the costs to which limits imposed under § 413.30 are applied in any cost reporting period will not exceed the lesser of the provider's actual cost or the limits imposed under § 413.30. If program reimbursement for items or services to which such limits are applied plus the charges to beneficiaries for such items or services imposed under this section exceed the provider's actual cost for such items or services, program payment to the provider will be reduced to the extent program payment plus charges to the beneficiaries exceed actual cost. If the provider's actual cost for general routine services in 1975 was \$57,000, the cost limit was \$58,000, and billed charges to Medicare Part A beneficiaries were \$2,000, the provider would receive \$55,000 from the

program (\$57,000 actual cost minus the \$2,000 in charges to the beneficiaries).

(d) *Definition of emergency services.* For purposes of paragraph (a)(2) of this section, emergency services are those hospital services that are necessary to prevent the death or serious impairment of the health of the individual, and which, because of the threat to the life or health of the individual, necessitate the use of the most accessible hospital (as determined under § 424.106 of this chapter) available and equipped to furnish such services. If an individual has been admitted to such hospital as an inpatient because of an emergency, the emergency will be deemed to continue until it is safe from a medical standpoint to move the individual to another hospital or other institution or to discharge him.

(e) *Identification of charges to individual.* For purposes of paragraph (a)(5) of this section, a provider must give or send to the individual or his representative, a schedule of all items and services that the individual might need and for which the provider imposes charges under this section, and the charge for each. Such schedule must specify that the charges are necessary to meet the costs in excess of the costs determined to be necessary in the efficient delivery of needed health services under Medicare and include such other information as CMS considers necessary to protect the individual's rights under this section. The provider, in arranging for the individual's admission, first service, or start of care, must give or send this schedule to the individual or his representative when arrangements are being made for such services or if this is not feasible, as soon thereafter as is practicable but no later than at the initiation of services.

[51 FR 34793, Sept. 30, 1986, as amended at 53 FR 6648, Mar. 20, 1988; 60 FR 45849, Sept. 1, 1995]

**§ 413.40 Ceiling on the rate of increase in hospital inpatient costs.**

(a) *Introduction*—(1) *Scope.* This section implements section 1886(b) of the Act, establishing a ceiling on the rate of increase in operating costs per case for hospital inpatient services furnished to Medicare beneficiaries that will be recognized as reasonable for

purposes of determining the amount of Medicare payment. This rate-of-increase ceiling applies to hospital cost reporting periods beginning on or after October 1, 1982. This section also sets forth rules governing exemptions from and adjustments to the ceiling.

(2) *Applicability.* (i) This section is not applicable to—

(A) Hospitals reimbursed in accordance with section 1814(b)(3) of the Act or under State reimbursement control systems that have been approved under section 1886(c) of the Act and subpart C of part 403 of this chapter; or

(B) Hospitals that are paid under the prospective payment systems for inpatient hospital services in accordance with section 1886 (d) and (g) of the Act and part 412 of this chapter.

(C) Rehabilitation hospitals and rehabilitation units that are paid under the prospective payment system for inpatient hospital services in accordance with section 1886(j) of the Act and subpart P of part 412 of this subchapter for cost reporting periods beginning on or after January 1, 2002.

(D) Long-term care hospitals, as defined in section 1886(d)(1)(B)(iv) of the Act, that are paid based on 100 percent of the Federal prospective payment rate for inpatient hospital services in accordance with section 123 of Public Law 106-113 and section 307 of Public Law 106-554 and § 412.533(b) and (c) of subpart O of Part 412 of this subchapter for cost reporting periods beginning on or after October 1, 2002.

(ii) For cost reporting periods beginning on or after October 1, 1983, this section applies to—

(A) Hospitals excluded from the prospective payment systems described in § 412.1(a)(1) of this subchapter;

(B) Psychiatric and rehabilitation units excluded from the prospective payment systems, as described in § 412.1(a)(1) of this chapter and in accordance with §§ 412.25 through 412.30 of this chapter, except as limited by paragraph (a)(2)(iii) of this section with respect to rehabilitation hospitals and rehabilitation units specified in §§ 412.23(b), 412.27, and 412.29 of this subchapter; and

(C) Long-term care hospitals excluded from the prospective payment systems described in § 412.1(a)(1) of this

subchapter and in accordance with § 412.23 of this subchapter, except as limited by paragraph (a)(2)(iv) of this section with respect to long-term care hospitals specified in § 412.23(e) of this subchapter.

(iii) For cost reporting periods beginning on or after October 1, 1983 and before January 1, 2002, this section applies to rehabilitation hospitals and rehabilitation units that are excluded from the prospective payment systems described in § 412.1(a)(1) of this subchapter.

(iv) For cost reporting periods beginning on or after October 1, 1983 and before October 1, 2002, this section applies to long-term care hospitals that are excluded from the prospective payment systems described in § 412.1(a)(1) of this subchapter. For cost reporting periods beginning on or after October 1, 2002, and before October 1, 2006, this section also applies to long-term care hospitals, subject to paragraph (a)(2)(i)(D) of this section.

(3) *Definitions.* As used in this section—

*Ceiling* is the aggregate upper limit on the amount of a hospital's net Medicare inpatient operating costs that the program will recognize for payment purposes. For each cost reporting period, the ceiling is determined by multiplying the updated target amount, as defined in this paragraph, for that period by the number of Medicare discharges during that period. For a hospital-within-a-hospital, as described in § 412.22(e) of this chapter, the number of Medicare discharges in a cost reporting period does not include discharges of a patient to another hospital in the same building on or on the same campus, if—

(A) The patient is subsequently readmitted to the hospital-within-a-hospital directly from the other hospital; and

(B) The hospital-within-a-hospital has discharged to the other hospital and subsequently readmitted more than 5 percent (that is, in excess of 5.0 percent) of the total number of Medicare inpatients discharged from the hospital-within-a-hospital in that cost reporting period.

*Date of discharge* is the earliest of the following dates:

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(A) The date the patient has exhausted Medicare Part A hospital inpatient benefits (including the election to use lifetime reserve days) during his or her spell of illness.

(B) The date the patient is formally released as specified in §412.4(a)(1) of this chapter.

(C) The date the patient is transferred to another facility.

(D) The date the patient dies.

*Market basket index* is CMS's projection of the annual percentage increase in hospital inpatient operating costs. The market basket index is a wage and price index that incorporates weighted indicators of changes in wages and prices that are representative of the mix of goods and services included in the most common categories of hospital inpatient operating costs subject to the ceiling, as described in paragraph (c)(1) of this section.

*Net inpatient operating costs* include the costs of certain preadmission services as specified in §413.40(c)(2), the costs of routine services, ancillary services, and intensive care services (as defined in §413.53(b)) incurred by a hospital in furnishing covered inpatient services to Medicare beneficiaries. Net inpatient operating costs exclude capital-related costs as described in §413.130, the costs of approved medical education programs as described in §§413.85 and 413.86, and heart, kidney, and liver acquisition costs incurred by approved transplantation centers. These costs are identified and excluded from inpatient operating costs before the application of the ceiling.

*Rate-of-increase percentage* is the percentage by which each hospital's target amount from the preceding Federal fiscal year is increased.

*Target amount* is the per discharge (case) limitation, derived from the hospital's allowable net Medicare inpatient operating costs in the hospital's base year, and updated for each subsequent hospital cost reporting period by the appropriate annual rate-of-increase percentage.

*Update adjustment percentage* is the percentage by which a hospital's allowable inpatient operating service costs for the 12-month cost reporting period beginning in Federal fiscal year 1990

exceeds the hospital's ceiling for that period.

*Update factor* is the decimal equivalent of the rate-of-increase percentage. The update factor is the value by which a hospital's target amount for the preceding year is multiplied in order to determine the target amount for the following year. For example, if the rate-of-increase percentage for a year is 2.7 percent, the update factor for that year is 1.027.

(b) *Cost reporting periods subject to the rate-of-increase ceiling.* (1) *Base period.* Each hospital's target amount is based on its allowable net inpatient operating costs per case from the cost reporting period of at least 12 months immediately preceding the first cost reporting period subject to the rate-of-increase ceiling established under this section. If the immediately preceding cost reporting period is a short reporting period (fewer than 12 months), the first period of at least 12 months subsequent to that short period is the base period.

(i) The target amount established under this provision remains applicable to a hospital or excluded hospital unit, as described in §§412.25 through 412.30 of this chapter, despite intervening cost reporting periods during which the hospital or excluded hospital unit is not subject to the ceiling as a result of other provisions of the law or regulations, or nonparticipation in the Medicare program, unless the hospital or excluded hospital unit qualifies as a new hospital or excluded part hospital unit under the provisions of paragraph (f) of this section.

(ii) The base period for a newly established excluded unit is the first cost reporting period of at least 12 months following the unit's certification to participate in the Medicare program.

(iii) When the operational structure of a hospital or unit changes (that is, a freestanding hospital becomes an excluded unit or an excluded unit becomes a freestanding hospital, or an entity of a multicampus hospital becomes a newly created hospital or unit or a hospital or unit becomes a part of a multicampus hospital), the base period for the hospital or unit that changed its operational structure is the first cost reporting period of at

least 12 months effective with the revised Medicare certification classification.

(iv) *Request for rebased target amount for the cost reporting period beginning on or after October 1, 1997 and on or before September 30, 1998.* Except for qualified long-term care hospitals as defined in paragraph (b)(1)(v) of this section, each hospital or unit under present or previous ownership that received payment under section 1886(b) of the Act during cost reporting periods beginning before October 1, 1990, may submit a request to its fiscal intermediary to rebase its target amount. The request must be received by the fiscal intermediary by the later of November 1, 1997 or 60 days before the beginning of its cost reporting period beginning during fiscal year 1998. The rebased target amount for the cost reporting period beginning during fiscal year 1998 is determined as follows:

(A) Determine the hospital's inpatient operating costs per case for each of the five most recent settled cost reports as of August 5, 1997.

(B) For each of the five cost reports, update the operating costs per case by the applicable update factors up to the hospital's cost reporting period beginning during FY 1998.

(C) Exclude the highest and lowest of the five updated amounts determined under paragraph (b)(1)(iv)(B) of this section.

(D) Compute the average for the remaining three updated amounts for operating cost per case.

(v) *Request by qualified long-term care hospital.* A qualified long-term care hospital may file a request to its fiscal intermediary for a rebased FY 1998 target amount. The request must be received by the fiscal intermediary by the later of November 1, 1997 or 60 days before the beginning of its cost reporting period beginning during fiscal year 1998. The rebased FY 1998 target amount is the hospital's FY 1996 inpatient operating costs updated to FY 1997. A qualified long-term care hospital means a long-term care hospital that meets the following two conditions for its two most recent settled cost reports as of August 5, 1997:

(A) Its Medicare inpatient operating costs exceed 115 percent of the ceiling.

(B) The hospital would have had a disproportionate patient percentage (as defined in § 412.106) equal to or greater than 70 percent if it were a prospective payment hospital.

(2) *Periods subject to the ceiling.* The ceiling established under this section applies to all cost reporting periods that—

(i) Begin on or after October 1, 1982; and

(ii) Immediately follow the base period established under paragraph (b)(1) of this section unless the exception in paragraph (b)(3) of this section is applicable.

(3) *Periods of other than 12 months.* The ceiling established under this section does not apply to cost reporting periods of fewer than 12 months that occur in conjunction with a change in operation of the facility, as defined in paragraph (b)(1)(iii) of this section, as a result of changes in ownership, merger, or consolidation. However, the ceiling applies to cost reporting periods of fewer than 12 months that result solely from the approval of a hospital's request for a change in accounting cycle, as specified in § 413.24(f)(3).

(c) *Costs subject to the ceiling—(1) Applicability.* The ceiling established under this section applies to net operating costs incurred by a hospital in furnishing inpatient hospital services to Medicare beneficiaries.

(2) Preadmission services otherwise payable under Medicare Part B furnished to a beneficiary during the calendar day immediately preceding the date of the beneficiary's admission to the hospital that meet the following conditions:

(i) The services are furnished by the hospital or any entity wholly owned or operated by the hospital. An entity is wholly owned by the hospital if the hospital is the sole owner of the entity. An entity is wholly operated by a hospital if the hospital has exclusive responsibility for conducting and overseeing the entity's routine operations, regardless of whether the hospital also has policymaking authority over the entity.

(ii) For services furnished after January 1, 1991, the services are diagnostic (including clinical diagnostic laboratory tests).

(iii) For services furnished on or after October 1, 1991, the services are furnished in connection with the principal diagnosis that requires the beneficiary to be admitted as an inpatient and are not the following:

- (A) Ambulance services.
- (B) Maintenance renal dialysis.

(3) *Rate-of-increase percentages and update factors.* The applicable rate-of-increase percentages and update factors are determined as follows:

(i) *Federal fiscal year 1986.* The applicable rate-of-increase percentage for cost reporting periods beginning on or after October 1, 1985 and before September 30, 1986 is five twenty-fourths of one percent, and the update factor is 1.00208333. For purposes of determining the target amount for cost reporting periods beginning on or after October 1, 1986, the applicable percentage increase for cost reporting periods beginning during Federal fiscal year 1986 is deemed to have been one-half percent, and the update factor is 1.005.

(ii) *Federal fiscal year 1987.* The applicable rate-of-increase percentage for cost reporting periods beginning on or after October 1, 1986 and before September 30, 1987 is 1.15 percent; the update factor is 1.0115.

(iii) *Federal fiscal year 1988.* The applicable rate-of-increase percentage for cost reporting periods beginning on or after October 1, 1987 and before October 1, 1988 is 2.3238 percent; the update factor is 1.023238. For purposes of updating the target amount for cost reporting periods beginning on or after October 1, 1988, the rate-of-increase percentage for cost reporting periods beginning during FY 1988 is deemed to have been 2.7 percent; the update factor is deemed to have been 1.027.

(iv) *Federal fiscal year 1989 through Federal fiscal year 1993.* The applicable rate-of-increase percentage for cost reporting periods beginning on or after October 1, 1988, and before October 1, 1993, is the percentage increase projected by the hospital market basket index (as defined in paragraph (a)(3) of this section).

(v) *Federal fiscal year 1994 through Federal fiscal year 1997.* The applicable rate-of-increase percentage for cost reporting periods beginning on or after October 1, 1993, and before October 1,

1998, is the market basket percentage increase minus the lesser of, 1 percentage point, or the percentage point difference between 10 percent and the hospital's "update adjustment percentage" (as defined in paragraph (a)(3) of this section); for hospitals with an "update adjustment percentage" of at least 10 percent, the applicable rate-of-increase percentage is the market basket percentage increase. The "update adjustment percentage" is increased in each Federal fiscal year by the sum of the hospital's applicable reductions applied to the market basket percentage increase for previous Federal fiscal years.

(vi) *Federal fiscal year 1998.* The applicable rate-of-increase percentage for cost reporting periods beginning on or after October 1, 1997 is 0 percent.

(vii) *Federal fiscal year 1999 through Federal fiscal year 2002.* The applicable rate-of-increase percentage for cost reporting periods beginning on or after October 1, 1998, and before October 1, 2002, based on data from the most recent available cost report, is:

(A) The percentage increase in the market basket, if inpatient operating costs are equal to or exceed the ceiling amount by 10 percent or more of the ceiling.

(B) The percentage increase in the market basket minus .25 percentage points for each percentage point by which inpatient operating costs are less than 10 percent over the ceiling (but not less than 0), if inpatient operating costs exceed the ceiling by less than 10 percent of the ceiling.

(C) The greater of the percentage increase in the market basket minus 2.5 percentage points or 0 percent, if inpatient operating costs are equal to or less than the ceiling but greater than 66.7 percent of the ceiling.

(D) 0 percent, if inpatient operating costs do not exceed 66.7 percent of the ceiling.

(viii) *Federal fiscal year 2003 and following.* The applicable rate-of-increase percentage for cost reporting periods beginning on or after October 1, 2002, is the percentage increase projected by the hospital market basket index.

(4) *Target amounts.* The intermediary will establish a target amount for each hospital. The target amount for a cost

reporting period is determined as follows:

(i) Except as provided in paragraph (c)(4)(iv) of this section, and subject to the provisions of paragraph (c)(4)(iii) of this section, for the first cost reporting period to which this ceiling applies, the target amount equals the hospital's allowable net inpatient operating costs per case for the hospital's base period increased by the update factor for the subject period.

(ii) Subject to the provisions of paragraph (c)(4)(iii) of this section, for subsequent cost reporting periods, the target amount equals the hospital's target amount for the previous cost reporting period increased by the update factor for the subject cost reporting period, unless the provisions of paragraph (c)(5)(ii) of this section apply.

(iii) In the case of a psychiatric hospital or unit, rehabilitation hospital or unit, or long-term care hospital, the target amount is the lower of the amounts specified in paragraph (c)(4)(iii)(A) or (c)(4)(iii)(B) of this section.

(A) The hospital-specific target amount.

(1) In the case of all hospitals and units, except long-term care hospitals for cost reporting periods beginning on or after October 1, 2001, the hospital-specific target amount is the net allowable costs in a base period increased by the applicable update factors.

(2) In the case of long-term care hospitals, for cost reporting periods beginning on or after October 1, 2000, the hospital-specific target amount is the net allowable costs in a base period increased by the applicable update factors multiplied by 1.25.

(B) One of the following for the applicable cost reporting period—

(1) For cost reporting periods beginning during fiscal year 1998, the 75th percentile of target amounts for hospitals in the same class (psychiatric hospital or unit, rehabilitation hospital or unit, or long-term care hospital) for cost reporting periods ending during FY 1996, increased by the applicable market basket percentage up to the first cost reporting period beginning on or after October 1, 1997.

(2) For cost reporting periods beginning during fiscal year 1999, the

amount determined under paragraph (c)(4)(iii)(B)(1) of this section, increased by the market basket percentage up through the subject period, subject to the provisions of paragraph (c)(4)(iv) of this section.

(3) For cost reporting periods beginning during fiscal year 2000—

(i) The labor-related portion and the nonlabor-related portion of the wage-neutralized 75th percentile of target amounts for hospitals in the same class (psychiatric hospital or unit, rehabilitation hospital or unit, or long-term care hospital) for cost reporting periods ending during FY 1996, are increased by the applicable market basket percentage up to the first cost reporting period beginning on or after October 1, 1999.

(ii) The labor-related portion of the wage-neutralized 75th percentile target amounts under paragraph (c)(4)(iii)(B)(4)(i) of this section is wage adjusted by multiplying it by the hospital's FY 2000 hospital inpatient prospective payment system wage index.

(iii) The wage-adjusted 75th percentile target amounts for hospitals in the same class is determined by adding the nonlabor-related portion of the wage-neutralized 75th percentile target amounts under paragraph (c)(4)(iii)(B)(3)(i) of this section and the hospital's wage-adjusted labor-related portion of the wage-neutralized 75th percentile target amounts determined under paragraph (c)(4)(iii)(B)(3)(ii) of this section, subject to the provisions of paragraph (c)(4)(iv) of this section.

(4) For cost reporting periods beginning during fiscal years 2001 and 2002—

(i) The amounts determined under paragraph (c)(4)(iii)(B) (3) (i) of this section are: increased by the market basket percentage up through the subject period; or in the case of a long-term care hospital, for cost reporting periods beginning on or after October 1, 2001, the amounts determined under paragraph (c)(4)(iii)(B)(3)(i) of this section increased by the market basket percentage up through the subject period and further increased by 2 percent.

(ii) The labor-related portion of the wage-neutralized 75th percentile target amounts under paragraph (c)(4)(iii)(B)(4)(i) of this section is wage-adjusted by multiplying by the

hospital's FY 2001 hospital inpatient prospective payment system wage index, for cost reporting periods beginning during fiscal year 2001 and the hospital's FY 2002 hospital inpatient prospective payment system wage index for cost reporting periods beginning during fiscal year 2002.

(iii) The wage-adjusted 75th percentile target amounts for hospitals in the same class are determined by adding the nonlabor-related portion of the wage-neutralized 75th percentile target amounts under paragraph (c)(4)(iii)(B)(4)(i) of this section and the hospital's wage-adjusted labor-related portion of the wage-neutralized 75th percentile target amounts determined under paragraph (c)(4)(iii)(B)(4)(ii) of this section, subject to the provisions of paragraph (c)(4)(iv) of this section.

(iv) For purposes of the limits on target amounts established under paragraph (c)(4)(iii) of this section, each hospital or unit that qualifies for exclusion as a member of only one class of excluded facility (psychiatric hospital or unit, rehabilitation hospital or unit, or long-term care hospital) will be subject to the limit applicable to that class. If a hospital or unit qualifies to be classified in more than one way under the exclusion criteria in subpart B of part 412 of this chapter, the hospital's or unit's target amount may not exceed the lowest applicable limit.

(v) In the case of a hospital that received payments under paragraph (f)(2)(ii) of this section as a newly created hospital or unit, to determine the hospital's target amount for the hospital's third 12-month cost reporting period, the payment amount determined under paragraph (f)(2)(ii)(A) of this section for the preceding cost reporting period is updated to the third cost reporting period.

(5) *Applicable update factor.* (i) The applicable update factor is derived from the prospectively determined rate-of-increase percentage published by CMS. The update factor for each Federal fiscal year is applied prospectively to the target amount for each cost reporting period beginning during the Federal fiscal year.

(ii) In the case of cost reporting periods of less than 12 months, the target

amount determined for a hospital's first cost reporting period beginning in a Federal fiscal year applies to subsequent periods beginning in the same Federal fiscal year.

(d) *Application of the target amount in determining the amount of payment.* (1) *General process.* (i) At the end of each cost reporting period subject to this section, the hospital's intermediary will compare a hospital's allowable net inpatient operating costs with that hospital's ceiling (as defined in paragraph (a)(3) of this section) for that period.

(ii) The hospital's actual allowable costs will be determined without regard to the lesser of cost or charges provisions of § 413.13, and in accordance with the provisions of paragraphs (d)(2) or (d)(3) of this section, as applicable.

(2) *Net inpatient operating costs are less than or equal to the ceiling.* (i) For cost reporting periods beginning on or after October 1, 1997, if a hospital's allowable net inpatient operating costs do not exceed the hospital's ceiling, payment to the hospital will be determined on the basis of the lower of the—

(A) Net inpatient operating costs plus 15 percent of the difference between inpatient operating costs and the ceiling; or

(B) Net inpatient operating costs plus 2 percent of the ceiling.

(ii) For psychiatric hospitals and units, for cost reporting periods beginning on or after October 1, 2000 and before October 1, 2001, if a hospital's allowable net inpatient operating costs do not exceed the hospital's ceiling, payment to the hospital will be determined on the basis of the lower of the—

(A) Net inpatient operating costs plus 15 percent of the difference between inpatient operating costs and the ceiling; or

(B) Net inpatient costs plus 3 percent of the ceiling.

(3) *Net inpatient operating costs are greater than the ceiling.* For cost reporting periods beginning on or after October 1, 1997—

(i) If a hospital's allowable net inpatient operating costs do not exceed 110 percent of the ceiling (or the adjusted ceiling, if applicable), payment will be the ceiling (or the adjusted ceiling, if applicable);

(ii) If a hospital's allowable net inpatient operating costs are greater than 110 percent of the ceiling (or the adjusted ceiling, if applicable), payment will be the ceiling (or the adjusted ceiling, if applicable) plus the lesser of:

(A) 50 percent of the allowable net inpatient operating costs in excess of 110 percent of the ceiling (or the adjusted ceiling, if applicable); or

(B) 10 percent of the ceiling (or the adjusted ceiling, if applicable).

(4) *Continuous improvement bonus payments.* (i) For cost reporting periods beginning on or after October 1, 1997 and ending before October 1, 2000, eligible hospitals (as defined in paragraph (d)(5) of this section) receive payments in addition to those in paragraph (d)(2) of this section, as applicable. These payments are equal to the lesser of—

(A) 50 percent of the amount by which the operating costs are less than the expected costs for the period; or

(B) 1 percent of the ceiling.

(ii) For cost reporting periods beginning on or after October 1, 2000, and ending before September 30, 2001, eligible psychiatric hospitals and units and long-term care hospitals (as defined in paragraph (d)(5) of this section) receive payments in addition to those in paragraph (d)(2) of this section, as applicable. These payments are equal to the lesser of—

(A) 50 percent of the amount by which the operating costs are less than the expected costs for the period; or

(B) 1.5 percent of the ceiling.

(iii) For cost reporting periods beginning on or after October 1, 2001, and before September 30, 2002, eligible psychiatric hospitals and units and long-term care hospitals receive payments in addition to those in paragraph (d)(5) of this section, as applicable. These payments are equal to the lesser of—

(A) 50 percent of the amount by which the operating costs are less than the expected costs for the periods; or

(B) 2 percent of the ceiling.

(5) *Eligibility requirements for continuous improvement bonus payments.* To qualify, a hospital must have been paid as a prospective payment excluded hospital for at least three full cost reporting periods prior to the applicable period, and the hospital's operating costs

per discharge for the period must be less than the least of the following:

(i) The hospital's target amount.

(ii) The hospital's trended costs.

(A) For a hospital for which its cost reporting period ending during fiscal year 1996 was its third or subsequent full cost reporting period, trended costs are the lesser of the allowable inpatient operating costs per discharge or the target amount for the cost reporting period ending in fiscal year 1996, increased in a compounded manner for each succeeding fiscal year by the market basket percentage increase;

(B) For all other hospitals, trended costs are the allowable inpatient operating costs per discharge for its third full cost reporting period increased in a compounded manner for each succeeding fiscal year by the market basket increase.

(iii) The hospital's expected costs. The hospital's expected costs are the lesser of its allowable inpatient operating costs per discharge or the target amount for the previous cost reporting period, updated by the market basket percentage increase for the fiscal year.

(e) *Hospital requests regarding adjustments to the payment allowed under the rate-of-increase ceiling.* (1) *Timing of application.* A hospital may request an adjustment to the rate-of-increase ceiling imposed under this section. The hospital's request must be received by the hospital's fiscal intermediary no later than 180 days after the date on the intermediary's initial notice of amount of program reimbursement (NPR) for the cost reporting period for which the hospital requests an adjustment.

(2) *Intermediary recommendation.* Unless CMS has authorized the intermediary to make the decision, the intermediary makes a recommendation on the hospital's request to CMS, which makes the decision. CMS issues a decision to the intermediary no later than 180 days after receipt of the completed application and the intermediary's recommendation.

(3) *Intermediary decision.* If CMS has authorized the intermediary to make the decision, the intermediary issues a decision no later than 180 days after receipt of the completed application.

(4) *Notification and review.* (i) The intermediary notifies the hospital of

the decision, including a full explanation of the grounds for the decision. A decision issued under paragraph (e)(2) or (e)(3) of this section is considered final unless the hospital submits additional information and requests a review of the decision no later than 180 days after the date on the intermediary's notice of the decision.

(ii) The final decision is subject to review under the provider reimbursement determination and appeal procedures in subpart R of part 405 of this chapter, provided the hospital has received an NPR for the cost reporting period in question, and the NPR disallows costs for which the hospital had requested an adjustment (see the definitions in §405.1801(a) of this chapter and the provisions regarding a provider's right to a Board hearing in §405.1835 of this chapter).

(5) *Extending time limit for PRRB review of NPR.* The time required to review the request is considered good cause for the granting of an extension of the time limit to apply for review of the notice of amount of program reimbursement by the Provider Reimbursement Review Board, as specified in §405.1841(b) of this chapter.

(6) *Applicability.* The provisions in paragraphs (e)(1) through (e)(5) of this section apply to a hospital's initial request for an adjustment and to a request for a review of the original decision based on additional data.

(f) *Comparison to the target amount for new hospitals and units—(1) New hospitals and units—(i) New hospitals.* For purposes of this section, a new hospital is a provider of hospital inpatient services that—

(A) Has operated as the type of hospital for which CMS granted it approval to participate in the Medicare program, under present or previous ownership (or both), for less than 2 full years; and

(B) Has provided the type of hospital inpatient services for which CMS granted it approval to participate in the Medicare program, for less than 2 years.

(ii) *New units.* A newly established unit that is excluded from the prospective payments system under the provisions of §§412.25 through 412.30 of this chapter does not qualify for the exemp-

tion afforded to a new hospital under paragraph (f)(2)(i) of this section unless the unit is located in an acute care hospital that, if it were subject to the provisions of this section, would qualify as a new hospital under paragraph (f)(1)(i) of this section.

(2) *Comparison—(i) Exemptions.* (A) A new children's hospital is exempt from the rate-of-increase ceiling imposed under this section. The exemption begins when the hospital accepts its first patient and ends at the end of the first cost reporting period ending at least 2 years after the hospital accepts its first patient. The first cost reporting period of at least 12 months beginning at least 1 year after the hospital accepts its first patient is the base year, in accordance with paragraph (b) of this section.

(B) Within 180 days of the date a hospital is excluded from the prospective payment system, the intermediary determines whether the hospital is exempt from the rate-of-increase ceiling. The intermediary notifies the hospital of its determination and the hospital's base period.

(C) A decision issued under paragraph (f)(2)(ii)(B) of this section is considered final unless the hospital submits additional information and requests a review of the decision no later than 180 days after the date on the intermediary's notice of the decision. The final decision is subject to review under subpart R of part 405 of this chapter, provided the hospital has received a notice of program reimbursement (NPR) for the cost reporting period in question and the NPR does not reflect an exemption (see the definitions in §405.1801(a) of this chapter and the provisions regarding a provider's right to a Board hearing in §405.1835 of this chapter).

(ii) *Median target amount.* (A) For cost reporting periods beginning on or after October 1, 1997, the amount of payment for a new psychiatric hospital or unit, a new rehabilitation hospital or unit, or a new long-term care hospital that was not paid as an excluded hospital prior to October 1, 1997, is the lower of the hospital's net inpatient operating cost per case or 110 percent of the national median of the target amounts for the class of excluded hospitals and

units (psychiatric, rehabilitation, long-term care) as adjusted for differences in wage levels and updated to the first cost reporting period in which the hospital receives payment. The second cost reporting period is subject to the same target amount as the first cost reporting period.

(B) The national median of the target amounts is the FY 1996 median target amount—

(1) Adjusted to account for differences in area wage levels;

(2) Updated by the market basket percentage increase to the fiscal year in which the hospital first received payments as an excluded provider.

(3) *Risk-basis HMOs*. Items or services that are furnished to beneficiaries enrolled in an HMO by a hospital that is either owned or operated by a risk-basis HMO or related to a risk-basis HMO by common ownership or control are exempt from the rate-of-increase ceiling (see the definition of an entity with a risk sharing contract in § 417.401 of this chapter).

(g) *Adjustments*—(1) *General rules*. (i) CMS adjusts the amount of the operating costs considered in establishing the rate-of-increase ceiling for one or more cost reporting periods, including both periods subject to the ceiling and the hospital's base period, under the circumstances specified in paragraphs (g)(2), (g)(3), and (g)(4) of this section.

(ii) When the hospital requests an adjustment, CMS makes an adjustment only to the extent that the hospital's operating costs are reasonable, attributable to the circumstances specified separately, identified by the hospital, and verified by the intermediary.

(iii) When the hospital requests an adjustment, CMS makes an adjustment only if the hospital's operating costs exceed the rate-of-increase ceiling imposed under this section.

(iv) In the case of a psychiatric hospital or unit, rehabilitation hospital or unit, or long-term care hospital, the amount of payment under paragraph (g)(3) of this section may not exceed the payment amount based on the target amount determined under paragraph (c)(4)(iii) of this section.

(v) In the case of a hospital or unit that received a revised FY 1998 target amount under the rebasing provisions

of paragraph (b)(1)(iv) of this section, the amount of an adjustment payment for a cost reporting period is based on a comparison of the hospital's operating costs for the cost reporting period to the average costs and statistics for the cost reporting periods used to determine the FY 1998 rebased target amount.

(2) *Extraordinary circumstances*. CMS may make an adjustment to take into account unusual costs (in either a cost reporting period subject to the ceiling or the hospital's base period) due to extraordinary circumstances beyond the hospital's control. These circumstances include, but are not limited to, strikes, fire, earthquakes, floods, or similar unusual occurrences with substantial cost effects.

(3) *Comparability of cost reporting periods*—(i) *Adjustment for distortion*. CMS may make an adjustment to take into account factors that would result in a significant distortion in the operating costs of inpatient hospital services between the base year and the cost reporting period subject to the limits.

(ii) *Factors*. The adjustments described in paragraph (g)(3)(i) of this section, include, but are not limited to, adjustments to take into account:

(A) FICA taxes (if the hospital did not incur costs for FICA taxes in its base period).

(B) Services billed under part B of Medicare during the base period, but paid under part A during the subject cost reporting period.

(C) Malpractice insurance costs (if malpractice costs were not included in the base year operating costs).

(D) Increases in service intensity or length of stay attributable to changes in the type of patient served.

(E) A change in the inpatient hospital services that a hospital provides, and that are customarily provided directly by similar hospitals, such as an addition or discontinuation of services or treatment programs.

(F) The manipulation of discharges to increase reimbursement.

(iii) *Adjusting operating costs*. Without a formal request from a hospital, CMS may adjust the amount of operating costs determined under paragraph (c)(1) of this section to take into account

certain adjustments. These adjustments include, but are not limited to, adjustments under paragraphs (g)(3)(ii)(A), (B), (C), (E), and (F) of this section.

(4) *Significant wage increase.* (i) *Criteria.* CMS may make an adjustment to take into account a significant increase in wages occurring between the base period and the cost reporting period subject to the ceiling if there is a significant increase in the average hourly wage for the geographic area in which the hospital is located (determined by reference to the wage index for prospective payment hospitals without regard to geographic reclassifications under sections 1886(d)(8) and (10) of the Act). For this purpose, there is a significant wage increase if the wage index value based on wage survey data collected for the cost reporting period subject to the ceiling is at least 8.0 percent higher than the wage index value based on survey data collected for the base year cost reporting period. If survey data are not available for the cost reporting periods used in the comparison, the wage index value based on the latest available survey data collected prior to that cost reporting period is used.

(ii) *Amount of the adjustment.* The adjustment for a significant wage increase equals the amount by which the lesser of the following calculations exceeds 108 percent of the increase in the national average hourly earnings for hospital workers:

(A) The rate of increase in the average hourly wage in the geographic area (determined by applying the applicable increase in the area wage index value to the rate of increase in the national average hourly earnings for hospital workers).

(B) The rate of increase in the hospital's average hourly wage.

(5) *Adjustment limitations.* For cost reporting periods beginning on or after October 1, 1993, and before October 1, 2003, the payment reductions under paragraph (c)(3)(v) through (c)(3)(vii) of this section will not be considered when determining adjustments under this paragraph.

(h) [Reserved]

(i) *Assignment of a new base period.* (1) *General rule.* (i) Effective with cost re-

porting periods beginning on or after April 1, 1990, CMS may assign a new base period to establish a revised ceiling if the new base period is more representative of the reasonable and necessary cost of furnishing inpatient services and all the following conditions apply:

(A) The actual allowable inpatient costs of the hospital in the cost reporting period that would be affected by the revised ceiling exceed the target amount established under paragraph (c) of this section.

(B) The hospital documents that the higher costs are the result of substantial and permanent changes in furnishing patient care services since the base period. In making this determination, CMS takes into consideration the following factors:

(1) Changes in the services provided by the hospital.

(2) Changes in applicable technologies and medical practices.

(3) Differences in the severity of illness among patients or types of patients served.

(C) The adjustments described in paragraph (g) of this section would not result in recognition of the reasonable and necessary costs of providing inpatient services.

(ii) The revised ceiling is based on the necessary and proper costs incurred during the new base period.

(A) Increases in overhead costs (for example, administrative and general costs and housekeeping costs) are not taken into consideration unless the hospital documents that these increases result from substantial and permanent changes in furnishing patient care services.

(B) In determining whether wage increases are necessary and proper, CMS takes into consideration whether increases in wages and wage-related costs for hospitals in the labor market area exceed the national average increase.

(2) *New base period.* The new base period is the first cost reporting period that is 12 months or longer that reflects the substantial and permanent change.

(3) *New applicable rate-of-increase percentages and update factors.* The revised

target amount resulting from the assignment of a new base period is increased by the applicable rate-of-increase percentages (update factors) described in paragraph (c)(3) of this section.

(j) *Reduction to capital-related costs.* For psychiatric hospital and units, rehabilitation hospitals and units, and long-term care hospitals, the amount otherwise payable for capital-related costs for hospital inpatient services is reduced by 15 percent for portions of cost reporting periods occurring on or after October 1, 1997 through September 30, 2002.

[58 FR 46340, Sept. 1, 1993, as amended at 59 FR 1659, Jan. 12, 1994; 59 FR 45401, Sept. 1, 1994; 60 FR 45849, Sept. 1, 1995; 61 FR 2725, Jan. 29, 1996; 61 FR 46225, Aug. 30, 1996; 62 FR 46032, Aug. 29, 1997; 63 FR 6868, Feb. 11, 1998; 63 FR 26358, May 12, 1998; 63 FR 41004, July 31, 1998; 64 FR 41541, July 30, 1999; 65 FR 47049, 47108, Aug. 1, 2000; 66 FR 32194, June 13, 2001; 66 FR 41394, Aug. 7, 2001; 67 FR 50114, Aug. 1, 2002]

### Subpart D—Apportionment

#### § 413.50 Apportionment of allowable costs.

(a) Consistent with prevailing practice in which third-party organizations pay for health care on a cost basis, reimbursement under the Medicare program involves a determination of—

(1) Each provider's allowable costs for producing services; and

(2) The share of these costs which is to be borne by Medicare. The provider's costs are to be determined in accordance with the principles reviewed in the preceding discussion relating to allowable costs. The share to be borne by Medicare is to be determined in accordance with principles relating to apportionment of cost.

(b) In the study and consideration devoted to the method of apportioning costs, the objective has been to adopt methods for use under Medicare that would, to the extent reasonably possible, result in the program's share of a provider's total allowable costs being the same as the program's share of the provider's total services. This result is essential for carrying out the statutory directive that the program's payments to providers should be such that the

costs of covered services for beneficiaries would not be passed on to nonbeneficiaries, nor would the cost of services for nonbeneficiaries be borne by the program.

(c) A basic factor bearing upon apportionment of costs is that Medicare beneficiaries are not a cross section of the total population. Nor will they constitute a cross section of all patients receiving services from most of the providers that participate in the program. Available evidence shows that the use of services by persons age 65 and over differs significantly from other groups. Consequently, the objective sought in the determination of the Medicare share of a provider's total costs means that the methods used for apportionment must take into account the differences in the amount of services received by patients who are beneficiaries and other patients serviced by the provider.

(d) The method of cost reimbursement most widely used at the present time by third-party purchasers of inpatient hospital care apportions a provider's total costs among groups served on the basis of the relative number of days of care used. This method, commonly referred to as average-per-diem cost, does not take into account, variations in the amount of service which a day of care may represent and thereby assumes that the patients for whom payment is made on this basis are average in their use of service.

(e) In considering the average-per-diem method of apportioning cost for use under the program, the difficulty encountered is that the preponderance of presently available evidence strongly indicates that the over-age 65 patient is not typical from the standpoint of average-per-diem cost. On the average this patient stays in the hospital twice as long and therefore the ancillary services that he uses are averaged over the longer period of time, resulting in an average-per-diem cost for the aged alone, significantly below the average-per-diem for all patients.

(f) Moreover, the relative use of services by aged patients as compared to other patients differs significantly