CHAPTER 30

NON-PPS HOSPITALS AND DISTINCT PART UNITS

3000. HOSPITALS AND DISTINCT PART UNITS OF HOSPITALS EXCLUDED FROM PROSPECTIVE PAYMENT SYSTEM

Section 1886(b) of the Social Security Act (as amended by §101 of the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982) established a ceiling on the allowable rate of increase in hospital inpatient operating costs per discharge applicable to cost reporting periods beginning on or after October 1, 1982. Effective with cost reporting periods beginning on or after October 1, 1983, however, most hospitals are paid under the prospective payment system (PPS) as described in §2801. Hospitals and units excluded from PPS (rehabilitation, psychiatric, children's, and long term hospitals; hospitals outside the 50 states, the District of Columbia, and Puerto Rico; hospitals reimbursed under special arrangements; and distinct part rehabilitation and psychiatric units) continue to be reimbursed under the TEFRA provision. Hospitals classified as cancer hospitals on or before December 19, 1989, are excluded from PPS effective with the first cost reporting period beginning on or after October 1, 1989. Hospitals classified as cancer hospitals after December 19, 1989, are excluded from PPS effective with the first cost reporting period beginning after the date of classification. For cost reporting periods beginning before October 1, 1985, and ending before October 1, 1987, alcohol/drug hospitals and units were also excluded from PPS. Effective with cost reporting periods beginning on and after October 1, 1987, these hospitals and units are paid under PPS. Under certain circumstances, HCFA may provide for an exemption from or an adjustment to the rate of increase ceiling or may assign a new base period.

Fiscal intermediaries are responsible for verifying on an annual basis compliance with the 75 percent rule for rehabilitation hospitals and units (§§3001.2B and 3001.7A); the age criterion for children's hospitals (§3001.3); the length of stay criterion for long-term care hospitals (§3001.4); and the cost finding and reporting requirements in §§3001.5G, H, I, J, and K.

3001. HOSPITALS AND DISTINCT PART UNITS OF HOSPITALS SUBJECT TO RATE OF INCREASE CEILING ON INPATIENT OPERATING COSTS

Excluded hospitals and excluded hospital distinct part units that meet the requirements outlined in this section are not subject to PPS for inpatient care but are paid on the basis of reasonable costs subject to a rate of increase ceiling on inpatient operating costs per discharge.

The following hospitals and hospital units are excluded from the prospective payment system and subject to the rate of increase ceiling:

- Psychiatric hospitals,
- Rehabilitation hospitals,
- Children's hospitals,
- Long term hospitals,
- Psychiatric and rehabilitation distinct part units of general acute care hospitals,
- Cancer hospitals, and
- Hospitals outside the 50 States, the District of Columbia, and Puerto Rico.

The exclusion is not optional on the part of the hospital but is required if the hospital meets the criteria for exclusion.

Hospitals (or their distinct part units) that meet the exclusion criteria of §3001 to §3001.10 must notify (in writing) the HCFA Regional Office (RO) serving the State in which the hospital is located. (See the listing in §3001.11.) Hospitals currently participating as psychiatric hospitals are not required to provide this notification. Such notification must include:

- Name of hospital,
- Type of hospital/unit(s),
- Address,
- Current provider identification number,
- Name of contact person,
- Fiscal intermediary, and
- A statement that the hospital or distinct part unit meets the criteria for exclusion.

As noted in §3001.5, a hospital notice relating to a unit must identify the particular areas designated as the unit and specify the number of beds and square footage included in the unit. Room numbers or bed numbers must be used to identify the designated space. When possible, the hospital must make the notification no later than 5 months before the beginning of the cost reporting period for which it is seeking exclusion. The RO determines, based on information obtained by the State survey agency and the intermediary, whether exclusion is appropriate. If the RO disapproves the exclusion, it notifies the hospital of the decision. If the RO approves the exclusion, it notifies the hospital and the Medicare fiscal intermediary of excluded status and provider identification numbers. The hospital's claim to meeting applicable criteria is subject to verification. Hospitals and hospital units that have already been excluded are evaluated to determine whether they continue to meet the exclusion criteria, and the results of each evaluation are used in determining each facility's status for the next cost reporting period.

A determination of excluded or nonexcluded status for a hospital or hospital unit applies to the entire cost reporting period for which the determination is made. ROs make these determinations, generally on an annual basis. If a change in meeting applicable criteria occurs during a cost reporting period, the status already determined for that period remains in effect for the duration of the period. The change in the hospital's or unit's status (e.g., from excluded to not excluded) takes effect only at the start of the next cost reporting period. However, for cost reporting periods beginning on or after October 1, 1991, payments for services in some provisionally excluded rehabilitation hospitals, units, or groups of beds may have to be adjusted as described in §3001.10. In addition, if an existing hospital or unit becomes subject to the PPS at a time other than the start of its cost reporting period because of the beginning or end of a hospital's participation in an approved demonstration project or State reimbursement control program, exclusion is effective on the date the change occurs.

Hospitals and units that have already been excluded from the PPS need not reapply for exclusion. However, PPS-excluded rehabilitation hospitals/units and psychiatric units must self-attest, on an annual basis, that they continue to meet PPS exclusion criteria. In addition, all previously excluded hospitals/units are required to report any change in operations (e.g., expansion or downsizing) to the appropriate HCFA RO and to provide the State agency with a copy of the report within 10 days after the change occurs. All PPS-excluded facilities are notified by letter by the appropriate HCFA RO of the self-attestation and other procedures and requirements that apply to them.

3001.1 Psychiatric Hospitals.--A hospital participating as a psychiatric hospital under the special requirements in 42 CFR 482.60 through 482.62 is an excluded hospital.

3001.2 Rehabilitation Hospitals.--A hospital is an excluded rehabilitation hospital if it meets all of the following criteria.

A. The hospital has in effect an agreement to participate as a hospital.

B. During its most recent 12 month cost reporting period (i.e., the period immediately preceding the period for which the exclusion is effective), the hospital treated an inpatient population of which at least 75 percent required intensive rehabilitative services for the treatment of one or more of the following conditions:

- Stroke;
- Spinal cord injury;
- Congenital deformity;
- Amputation;
- Major multiple trauma;
- Fracture of femur (hip fracture);
- Brain injury;
- Polyarthritis, including rheumatoid arthritis;
- Neurological disorders, including multiple sclerosis, motor neuron diseases, polyneuropathy, muscular dystrophy, and Parkinson's disease; or
- Burns.

For purposes of determining whether this criterion is met, the medical conditions of all (i.e., Medicare and non-Medicare) patients treated in the hospital are considered. Either the number of admissions or the number of discharges during a cost reporting period may be used as the basis for this determination. The number of patient days of care may not be used in making the determination.

A hospital that seeks exclusion as a rehabilitation hospital for the first full 12 month cost reporting period beginning on or after the date it becomes a Medicare participating hospital may provide the intermediary with a written certification that the inpatient population it intends to serve meets this criterion instead of showing that it has treated such a population during its most recent 12 month cost reporting period. If the hospital provides such a certification, the written certification is effective for any cost reporting period of not less than one month and not more than 11 months between the date the hospital began participating in Medicare and the start of the hospital's regular 12 month cost reporting period. However, an adjustment to the payments for the period is made, as described in §3001.10, if the hospital does not actually meet the requirements of §3001.2B for the period.

C. The hospital has in effect a preadmission screening procedure under which each prospective patient's condition and medical history are reviewed to determine whether the patient is likely to benefit significantly from an intensive inpatient hospital rehabilitation program or assessment.

D. The hospital ensures that patients receive close medical supervision and furnishes, through the use of qualified personnel, rehabilitation nursing, physical therapy, and occupational therapy, plus, as needed, speech therapy, social or psychological services, and orthotic and prosthetic services.

E. The hospital has a plan of treatment for each inpatient that is established, reviewed, and revised, as needed, by a physician in consultation with other professional personnel who provide services to the patient.

F. The hospital uses a coordinated multidisciplinary team approach in the rehabilitation of each inpatient, as documented by periodic clinical entries made in the patient's medical record to note the patient's status in relationship to goal attainment, and ensures that team conferences are held at least every 2 weeks to determine the appropriateness of treatment.

G. The hospital has a director of rehabilitation who provides services to the hospital and its inpatients on a full time basis, is a Doctor of Medicine or Osteopathy, is licensed under State law to practice medicine or surgery, and has had, after completing a 1 year hospital internship, at least 2 years of training or experience in the medical management of inpatients requiring rehabilitation services.

3001.3 Children's Hospitals.--A hospital is an excluded children's hospital if it has in effect an agreement to participate as a hospital, and the majority of its inpatients in the most recent cost reporting period are individuals under the age of 18.

3001.4 Long Term Hospitals.--A hospital is an excluded long term hospital if it has in effect an agreement to participate as a hospital and the average inpatient length of stay is greater than 25 days. The average length of inpatient stay must be computed by dividing the total number of inpatient days (less leave or pass days) by the number of total discharges for the hospital's most recently completed cost reporting period. Ordinarily, the determination regarding a hospital's average length of stay is based on the hospital's most recently filed cost report. However, if the hospital has not yet filed a cost report or if there is an indication that the most recently filed cost report does not accurately reflect the hospital's current average length of stay, data from the most recent 6 month period are used.

Hospitals that specialize in rehabilitation and meet the length of stay criterion as long term hospitals are eligible for a long term hospital exclusion and do not have to meet the special criteria established for rehabilitation hospitals.

3001.5 Psychiatric and Rehabilitation Units.--An excluded psychiatric unit must meet the general criteria for units as listed in items A through M and all of the specific criteria for psychiatric units in §3001.6. An excluded rehabilitation unit must meet the general criteria for units in items A through M and all of the specific criteria for rehabilitation units in §3001.7. The general criteria for the units follow.

A. The unit must be a part of an institution that has in effect an agreement to participate as a hospital that is not excluded in its entirety from the PPS.

B. The unit must have written admission criteria that are applied uniformly to both Medicare and non-Medicare patients.

C. The unit must have admission and discharge records that are separately identified from those of the hospital in which it is located and are readily retrievable. (However, the medical records of unit patients need not be physically separate from the records of patients in the acute care part of the hospital, and it is not necessary to create a second medical record when a patient is moved from the acute care part of the hospital to the excluded unit, or vice versa. The record must indicate the dates of the admission and discharge for patients of the unit.) The unit's policies must provide that necessary clinical information is transferred to the unit when a patient of the hospital is admitted to the unit.

D. If State law provides special licensing requirements for psychiatric or rehabilitation units, the unit must be licensed in accordance with the applicable requirements.

E. The hospital's utilization review plan must include separate standards for the type of care offered by the unit.

F. The beds assigned to the unit must be physically separate from (i.e., not commingled with) beds not included in the unit.

G. The hospital must have enough beds not excluded from the PPS to permit the provision of adequate cost information, as specified in Chapter 23.

H. The unit and the hospital in which it is located must be serviced by the same fiscal intermediary.

I. The unit must be treated as a separate cost center for cost finding and apportionment purposes.

J. The accounting system of the hospital in which the unit is located must provide for the proper allocation of costs and maintain statistical data that are adequate to support the basis of allocation.

K. The cost report for the hospital must include the costs of the unit, cover a single fiscal period, and reflect a single method of cost apportionment.

L. As of the first day of the first cost reporting period for which all other exclusion requirements are met, the unit must be fully equipped and staffed and must be capable of providing hospital inpatient psychiatric or rehabilitation care regardless of whether there are any inpatients in the unit on that date.

M. Each hospital may have only one unit of each type (psychiatric and rehabilitation) excluded from the PPS.

These criteria are used to determine whether a part of a hospital qualifies for exclusion from PPS. An excluded unit must be established as a separate cost entity for cost reporting purposes, using the criteria in §2336.1A through D for this purpose.

If a hospital wishes to have a unit excluded from PPS for a cost reporting period, it must notify its intermediary before the start of the period of the particular areas it has designated as the unit and of the square footage and number of beds in the unit. This notice must be sent to the intermediary at the same time notice is sent to the RO regarding the request for exclusion (see §3001) and must identify the designated space through the use of room numbers and/or bed numbers. After the initial designation, changes in the amount of the space occupied by the unit or in the number of beds in the unit are recognized for purposes of the exclusion only at the start of a cost reporting period.

Compliance with the criteria in items H, I, and J may be determined based on the hospital's most recently filed cost report or, if necessary, by the hospital's presentation of evidence that shows, to the satisfaction of the intermediary, that the hospital has the accounting capability to meet these criteria for the cost reporting period for which the exclusion, if approved, applies.

3001.6 Specific Criteria for Psychiatric Units.--

A. The unit must admit only patients whose admission to the unit is required for active treatment, whose treatment is of an intensity that can be provided only in an inpatient hospital setting, and whose condition is described by a psychiatric principal diagnosis contained in:

- the *Fourth* Edition of the American Psychiatric Association Diagnostic and Statistical Manual;
- Chapter 5 (Mental Disorders) of the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM); *or*
- *Chapter 5 (Mental and BehavioralDisorders) of the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM), upon implementation of ICD-10.*

B. The unit must furnish, through the use of qualified personnel, psycho-logical services, social work services, psychiatric nursing, occupational therapy, and recreational therapy.

C. The unit must maintain medical records that permit determination of the degree and intensity of treatment provided to individuals who are furnished services in the unit and that meet the following requirements.

1. Development of Assessment/Diagnostic Data.--Medical records must stress the psychiatric components of the record, including history of findings and treatment provided for the psychiatric condition for which the inpatient is treated in the unit. Medical records must meet the following criteria:

- o The identification data must include the inpatient's legal status;

- A provisional or admitting diagnosis must be made on every inpatient at the time of admission and must include the diagnoses of intercurrent diseases as well as the psychiatric diagnoses;

- The reasons for admission must be clearly documented as stated by the inpatient or others significantly involved or both;

- The social service records, including reports of interviews with inpatients, family members, and others, must provide an assessment of home plans and family attitudes, community resource contacts, and a social history; and

- When indicated, a complete neurological examination must be recorded at the time of the admission physical examination.

2. Psychiatric Evaluation.--Each inpatient must receive a psychiatric evaluation that must:

- Be completed within 60 hours of admission;

- Include a medical history;

- Contain a record of mental status;

- Note the onset of illness and the circumstances leading to admission;

- Describe attitudes and behavior;

- Estimate intellectual functioning, memory functioning, and orientation; and

- Include an inventory of the inpatient's assets in descriptive, not interpretative, fashion.

3. Treatment Plan.--Each inpatient must have an individual comprehensive treatment plan that must be based on an inventory of the inpatient's strengths and disabilities. The written plan must include a substantiated diagnosis; short term and long term goals; the specific treatment modalities utilized; the responsibilities of each member of the treatment team; and adequate documentation to justify the diagnosis and the treatment and rehabilitation activities carried out.

The treatment received by the inpatient must be documented in such a way as to assure that all active therapeutic efforts are included.

4. Recording Progress.--Progress notes must be recorded by the doctor of medicine or osteopathy responsible for the care of the inpatient, a nurse, social worker, and, when appropriate, others significantly involved in active treatment modalities. The frequency of progress notes is determined by the condition of the inpatient. The progress notes must be recorded at least weekly for the first 2 months and at least once a month thereafter. They also must contain recommendations for revisions in the treatment plan as indicated, as well as precise assessment of the inpatient's progress in accordance with the original or revised treatment plan.

5. Discharge Planning and Discharge Summary.--The record of each patient who has been discharged must contain a discharge summary that includes a recapitulation of the inpatient's hospitalization in the unit and recommendations from appropriate services concerning follow-up or aftercare, as well as a brief summary of the patient's condition on discharge.

D. The unit must meet special staff requirements, i.e., the unit must have adequate numbers of qualified professional and supportive staff to evaluate inpatients, formulate written, individualized, comprehensive treatment plans, provide active treatment measures, and engage in discharge planning, as follows:

1. Personnel.--The unit must employ or undertake to provide adequate numbers of qualified professional, technical, and consultative personnel to:

- Evaluate inpatients;
- Formulate written, individualized, comprehensive treatment plans;
- Provide active treatment measures; and
- Engage in discharge planning.

2. Director of Inpatient Psychiatric Services Medical Staff.--Inpatient psychiatric services must be under the supervision of a clinical director, service chief, or equivalent who is qualified to provide the leadership required for an intensive treatment program. The number and qualifications of doctors of medicine and osteopathy must be adequate to provide essential psychiatric services.

The clinical director, service chief, or equivalent must meet the training and experience requirements for examination by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry.
The director must monitor and evaluate the quality and appropriateness of services and treatment provided by the medical staff.

3. Nursing Services.--The unit must have a qualified director of psychiatric nursing services. In addition to the director of nursing, there must be adequate numbers of registered nurses, licensed practical nurses, and mental health workers to provide nursing care necessary under each inpatient's active treatment program and to maintain progress notes on each inpatient.

The director of psychiatric nursing services must be a registered nurse who has a master's degree in psychiatric or mental health nursing (or its equivalent) from an accredited school of nursing or is qualified by education and experience in the care of the mentally ill. The director must demonstrate competence to participate in interdisciplinary formulation of individual treatment plans, to give skilled nursing care and therapy, and to direct, monitor, and evaluate the nursing care furnished.

The staffing pattern must ensure the availability of a registered nurse 24 hours each day. There must be adequate numbers of registered nurses, licensed practical nurses, and mental health workers to provide the nursing care necessary under each inpatient's active treatment program.

4. Psychological Services.--The unit must provide or have available psychological services to meet the needs of the inpatients. The services must be furnished in accordance with accepted standards of practice, service objectives, and established policies and procedures.

5. Social Services.--There must be a director of social services who monitors and evaluates the quality and appropriateness of social services furnished. The services must be furnished in accordance with accepted standards of practice and established policies and procedures.

Social service staff responsibilities must include, but are not limited to, participating in discharge planning, arranging for follow up care, and developing mechanisms for exchange of appropriate information with sources outside the hospital.

6. Therapeutic Activities.--The unit must provide a therapeutic activities program. The program must be appropriate to the needs and interests of inpatients and be directed toward restoring and maintaining optimal levels of physical and psychosocial functioning.

The number of qualified therapists, support personnel, and consultants must be adequate to provide comprehensive therapeutic activities consistent with each inpatient's active treatment program.

3001.7 Specific Criteria for Rehabilitation Units.--

A. Except as provided in subsection B, the unit must have treated, during its most recent 12 month cost reporting period (i.e., the period immediately preceding the period for which the exclusion would be effective), an inpatient population that meets the requirement in §3001.2B.

B. For the first cost reporting period in which a currently participating hospital seeks exclusion of a new rehabilitation unit, it may provide a written certification that the inpatient population it intends the unit to serve meets the requirement in §3001.2B, instead of showing that it has treated such a population during its most recent 12 month cost reporting period. For purposes of this provision, a unit is considered new only if the hospital has not previously sought exclusion for any rehabilitation unit and has obtained approval for added bed capacity under its State licensure and its approved Medicare provider agreement. A unit of a currently participating hospital that includes some beds that were previously licensed and certified and some new beds is recognized as a new rehabilitation unit only if more than one-half of the beds are new.

A hospital that has not previously participated in the Medicare program and seeks exclusion of a rehabilitation unit may provide a written certification that the inpatient population it intends the unit to serve meets the requirement in §3001.2B, instead of showing that it has treated such a population during its most recent 12 month cost reporting period. The written certification is effective for the first full 12 month cost reporting period that occurs after the hospital becomes a Medicare participating hospital and for any cost reporting period of not less than 1 month and not more than 11 months occurring between the date the hospital began participating in Medicare and the start of the hospital's first regular 12 month cost reporting period of Medicare participation.

For purposes of this section, a hospital that has undergone a change of ownership or leasing is considered to have not participated previously in the Medicare program.

C. The unit must meet the requirements in §3001.2C through F.

D. The unit must have a director of rehabilitation who has the qualifications described in §3001.2G and provides services to the unit and its inpatients for at least 20 hours per week. If a rehabilitation unit serves both inpatients and outpatients through a single integrated unit, the time spent by the director in performing administrative duties for the entire unit counts toward the direction requirement since it is not feasible to prorate this administrative time between inpatients and outpatients. However, any time spent in furnishing direct patient care can count toward the direction requirement only if the care is furnished to inpatients.

3001.8 Expansion of Excluded Rehabilitation Units.--

A. Except as provided in subsection B, if a hospital expands its excluded rehabilitation unit by adding beds, the medical condition of the patients treated in the added beds during the most recent 12 month cost reporting period must be taken into account in determining whether the requirement in §3001.7A is met.

B. A hospital that has an excluded rehabilitation unit may obtain approval for added bed capacity under State licensure and under its approved Medicare provider agreement and may seek to add new beds to its existing excluded unit for the first 12 month cost reporting period during which the new beds are used to provide inpatient care. The hospital may provide a written certification that the inpatient population the new beds are intended to serve meets the requirement in §3001.2B, instead of showing that those beds were used to treat such a population during the unit's most recent 12 month cost reporting period.

For purposes of this provision, new beds are defined as additional beds for which the hospital has obtained approval for increasing its bed capacity under both State licensure and its approved Medicare provider agreement. For cost reporting periods beginning on or after October 1, 1991, an adjustment to payments for the period is made (as described in §3001.10) if the inpatient population of the added beds does not actually meet the requirements of §3001.2B for the period.

3001.9 Cancer Hospitals.--

A. A hospital is an excluded cancer hospital if it meets all of the following criteria:

o The hospital was recognized as a comprehensive cancer center or clinical cancer research center by the National Cancer Institute of the National Institutes of Health as of April 20, 1983;

o The hospital demonstrates that the entire facility is organized primarily for treatment of and research on cancer (i.e., the facility is not a subunit of a general acute care hospital or university-based medical center);

o The hospital shows that at least 50 percent of its total discharges have a principal diagnosis that reflects a finding of neoplastic disease. (The principal diagnosis for this purpose is defined as the condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital.); *and*

o The hospital was recognized by HCFA as a cancer hospital on or before December 31, 1990.

B. The effective date for exclusion from PPS follows.

o A hospital recognized as a cancer hospital on or before December 19, 1989, is excluded from the PPS effective with cost reporting periods beginning on or after October 1, 1989.

o A hospital recognized after December 19, 1989, is excluded from PPS effective with the cost reporting period beginning on or after the date of classification.

3001.10 Retroactive Adjustments for Provisionally Excluded Hospitals, Hospital Units, or Beds.--

A. If a hospital, hospital unit, or group of beds is excluded from the prospective payment system for a cost reporting period based on a written certification under §3001.2B (for new rehabilitation hospitals), §3001.7B (for new rehabilitation units), or §3001.8B (for beds added to existing rehabilitation units) but does not actually meet the requirements of any such section for that cost reporting period, HCFA adjusts its payments to the hospital retroactively in accordance with subsection C.

B. In the case of a unit to which new beds have been added under §3001.8B, the 75 percent requirement in §3001.2B is applied to the entire unit, including both new and added beds. If the entire unit is able to meet the requirement, the previously existing unit and the added beds are presumed to meet the requirement separately and no payment adjustment under subsection C is made. If the unit as a whole does not meet the 75 percent requirement, the hospital must furnish the intermediary or the State agency, as specified by the RO, the information needed to determine whether the 75 percent requirement was met by the established portion of the unit (that is, the previously existing unit) and by the newly added beds, considered separately. If the established portion of the unit did not meet the requirement, no retroactive payment adjustment is made for services in the established portion of the unit but that portion is not excluded from the PPS as a rehabilitation unit for the following cost reporting period. If the added beds met the requirement, no retroactive payment adjustment is made for the added beds and those beds are eligible for exclusion from the PPS as a rehabilitation unit for the following cost reporting period. If the added beds did not meet the requirement, the intermediary adjusts its payment to the unit retroactively in accordance with subsection C and the added beds are not excluded from the PPS as a rehabilitation unit for the following cost reporting period.

If the hospital does not have the records needed to discriminate between the performance of the previously existing unit and that of the added beds or for other reasons does not furnish the information requested by the intermediary or State agency, neither the previously existing unit nor the added beds are excluded from the PPS for the following cost reporting period. In that case, the intermediary adjusts its payment to the unit retroactively in accordance with subsection C.

C. The intermediary adjusts payment to the hospital by calculating the difference between the amount actually paid for services to Medicare patients in the hospital, hospital unit, or beds during the period of provisional exclusion and the amount that would have been paid if the hospital, unit, or

beds had not been excluded from the PPS. The intermediary then takes action to recover the resulting overpayment or corrects the underpayment to the hospital.

3001.11 Regional Office Listing.--

Region	Address	States Served
1	Health Care Financing Administration Division of Health Standards and Quality JFK Federal Building Room 1309 Boston, MA 02203 (617) 565-1322	Connecticut Maine Massachusetts New Hampshire Rhode Island Vermont
2	Health Care Financing Administration Division of Health Standards and Quality Room 3811 26 Federal Plaza New York, NY 10278 (212) 264-1121	New Jersey New York Puerto Rico Virgin Islands
3	Health Care Financing Administration Division of Health Standards and Quality P.O. Box 7760 3535 Market St. Philadelphia, PA 19101 (215) 596-6571	Delaware District of Columbia Maryland Pennsylvania Virginia West Virginia
4	Health Care Financing Administration Division of Health Standards and Quality Suite 701 101 Marietta Tower Atlanta, GA 30323 (404) 331-2361	Alabama Florida Georgia Kentucky Mississippi North Carolina South Carolina Tennessee
5	Health Care Financing Administration Division of Health Standards and Quality 15th Floor 105 West Adams Chicago, IL 60603 (312) 353-9805	Illinois Indiana Michigan Minnesota Ohio Wisconsin

Region	Address	States Served
6	Health Care Financing Administration Division of Health Standards and Quality Room 2000 1200 Main Tower Building Dallas, TX 75202 (214) 767-6301	Arkansas Louisiana New Mexico Oklahoma Texas
7	Health Care Financing Administration Division of Health Standards and Quality Room 235 601 East 12th Street Kansas City, MO 64106 (816) 426-2408	Iowa Kansas Missouri Nebraska
8	Health Care Financing Administration Division of Health Standards and Quality Room 1185 Federal Building 1961 Stout Street Denver, CO 80294 (303) 844-4721	Colorado Montana North Dakota South Dakota Utah Wyoming
9	Health Care Financing Administration Division of Health Standards and Quality 4th & 5th Floor 75 Hawthorne Street San Francisco, CA 94102 (415) 744-3679	American Samoa Arizona California Guam Hawaii Nevada
10	Health Care Financing Administration Division of Health Standards and Quality Mail Stop RX 40 2201 Sixth Avenue Seattle, WA 98121 (206) 442-0511	Alaska Idaho Oregon Washington

3002. CALCULATING RATE OF INCREASE CEILING ON HOSPITAL INPATIENT OPERATING COSTS

A hospital or hospital unit that is excluded from PPS is paid on the basis of reasonable cost subject to a rate of increase ceiling on inpatient operating costs. The ceiling is based on a target amount per discharge.

The hospital's target amount for a cost reporting period is equal to the hospital's allowable inpatient operating costs (excluding capital and medical education costs) per discharge for its base period (as defined in subsection A) increased by applicable update factors. To establish the first year's target amount, the intermediary determines the allowable inpatient operating

costs per discharge for the hospital's base period. This amount is then updated by the applicable percentage increase, yielding the hospital's per discharge target amount for the first cost reporting period subject to the rate of increase ceiling.

The target amount is then multiplied by Medicare discharges for the period, yielding the ceiling, which is the upper limit on net program operating cost. The target amount for a subsequent period is determined by multiplying the target amount for the immediately preceding period by the applicable update factor.

A. Base Year.--The first full 12 month cost reporting period immediately preceding the first cost reporting period that is subject to the rate of increase ceiling is the base year. For existing hospitals and units, this means cost reporting periods beginning in Federal FY 1982. For new hospitals, see §3003. The base year for newly established excluded units is the first 12 month cost reporting period under which the unit is excluded from the PPS.

For cost reporting periods beginning on or after April 1, 1989, a cancer hospital's base year for determining the rate of increase ceiling is the original TEFRA base year or the cost reporting period beginning during FY 1987, whichever results in a higher target amount.

B. Annual Target Amount Percentage Increases.--The annual percentage increase in the target amount is established by statute and published annually in the Federal Register in September. The update factors derived from these percentages are provided in the tables below. For FY 1994, the applicable rate of increase percentage is the market basket percentage increase (4.3 percent) less a percentage reduction determined as follows.

1. An update adjustment percentage is calculated by determining the percentage by which the hospital's costs subject to the ceiling exceed the hospital's ceiling for the 12 month cost reporting period beginning in FY 1990.

2. The reduction to the market basket percentage (applicable reduction) is calculated as the lesser of 1 percentage point or the result of subtracting the hospital's update adjustment percentage from 10 percent.

3. The applicable reduction is subtracted from the market basket percentage and results in the rate of increase percentage.

The following situations are exceptions to the method described above for determining the rate of increase percentage for FY 1994 through FY 1997:

- If the hospital's update adjustment percentage is 10 percent or more, there is no applicable reduction and its rate of increase percentage is the percentage increase in the hospital market basket.

- If a hospital's FY 1990 rate of increase ceiling was greater than cost subject to the ceiling, the rate of increase percentage is the percentage increase in the hospital market basket minus 1 percentage point.

- If a hospital did not have a 12 month cost reporting period beginning in FY 1990 that was subject to the rate of increase limitation, its applicable rate of increase percentage is the percentage increase in the hospital market basket minus 1 percentage point.

For FY 1995 through FY 1997, the update adjustment percentage is the update adjustment percentage from the hospital's previous year plus the previous year's applicable reduction. The applicable reduction and applicable rate of increase percentage for the hospital are then determined as described for FY 1994.

For FY 1998 and following, the applicable rate of increase percentage is the percentage increase in the hospital market basket.

EXAMPLE 1:

Cost reporting period beginning in FY 1990	
Allowable inpatient operating costs	$10,600
Rate of increase ceiling	$10,000
Percentage by which costs exceed ceiling	6.00%
FY 1994	
Update adjustment percentage (percentage by which costs exceed ceiling)	6.00%
Difference between 10% and update adjustment percentage	4.00%
Applicable reduction (lesser of 1% or the difference between 10% and the update adjustment percentage)	1.00%
Applicable rate of increase percentage is the market basket percentage increase minus the applicable reduction of 1%	
FY 1995	
Update adjustment percentage (last year's update adjustment percentage plus last year's applicable reduction)	7.00%
Difference between 10% and update adjustment percentage	3.00%
Applicable reduction (lesser of 1% or the difference between 10% and the update adjustment percentage)	1.00%
Applicable rate of increase percentage is the market basket percentage increase minus the applicable reduction of 1%	
FY 1996	
Update adjustment percentage (last year's update adjustment percentage plus last year's applicable reduction)	8.00%
Difference between 10% and update adjustment percentage	2.00%
Applicable reduction (lesser of 1% or the difference between 10% and the update adjustment percentage)	1.00%
Applicable rate of increase percentage is the market basket percentage increase minus the applicable reduction of 1%	

FY 1997

Update adjustment percentage (last year's update adjustment percentage plus last year's applicable reduction)	9.00%
Difference between 10% and the update adjustment percentage	1.00%
Applicable reduction (lesser of 1% or the difference between 10% and the update adjustment percentage)	1.00
Applicable rate of increase percentage is the market basket percentage increase minus the applicable reduction of 1%	

EXAMPLE 2:

Cost reporting period beginning in FY 1990	
Allowable inpatient operating costs	$10,800
Rate of increase ceiling	$10,000
Percentage by which costs exceed ceiling	8.00%

FY 1994

Update adjustment percentage (percentage by which costs exceed ceiling)	8.00%
Difference between 10% or update adjustment percentage	2.00%
Applicable reduction (lesser of 1% or the difference between 10% and the update adjustment percentage)	1.00%
Applicable rate of increase percentage is the market basket percentage increase minus the applicable reduction of 1%	

FY 1995

Update adjustment percentage (last year's update adjustment percentage plus last year's applicable reduction)	9.00%
Difference between 10% and update adjustment percentage	1.00%
Applicable reduction (lesser of 1% or the difference between 10% and the update adjustment percentage)	1.00%
Applicable rate of increase percentage is the market basket percentage increase minus the applicable reduction of 1%	

FY 1996

Update adjustment percentage (last year's update adjustment percentage plus last year's applicable reduction)	10.00%
Because the update adjustment percentage is at least 10%, the applicable rate of increase percentage for FY 1996 and FY 1997 is the market basket percentage increase	

EXAMPLE 3:

Cost reporting period beginning in FY 1990	
Allowable inpatient operating costs	$10,950
Rate of increase ceiling	$10,000
Percentage by which costs exceed ceiling	9.50%
FY 1994	
Update adjustment percentage (percentage by which costs exceed ceiling)	9.50%
Difference between 10% and update adjustment percentage	0.50%
Applicable reduction (lesser of 1% or the difference between 10% and the update adjustment percentage)	0.50%
Applicable rate of increase percentage is the market basket percentage increase minus the applicable reduction of 0.50%	
FY 1995	
Update adjustment percentage (last year's update adjustment percentage plus last year's applicable reduction)	10.00%
Because the update adjustment percentage is at least 10%, the applicable rate of increase percentage for FY 1995 through FY 1997 is the market basket percentage increase	

EXAMPLE 4:

Cost reporting period beginning in FY 1990	
Allowable inpatient operating costs	$9,000
Rate of increase ceiling	$10,000
Percentage by which costs exceed ceiling	0.00%
FY 1994	
Applicable reduction	1.00%
Because costs did not exceed the rate of increase ceiling in FY 1990, the applicable rate of increase percentage for FY 1994 through FY 1997 is the market basket percentage increase minus 1%	

UPDATE FACTOR TABLE

HOSPITAL FY ENDS	FEDERAL FY 1983 BEGINS 10/1/82	FEDERAL FY 1984 BEGINS 10/1/83	FEDERAL FY 1985 BEGINS 10/1/84	FEDERAL FY 1986 BEGINS 10/1/85	DEEMED FEDERAL FY 1986 BEGINS 10/1/85 1_/	FEDERAL FY 1987 BEGINS 10/1/86	FEDERAL FY 1988 BEGINS 10/1/87	DEEMED FEDERAL FY 1988 BEGINS 10/1/87 2_/
09/30	1.07975	1.06900	1.06625	1.00208333	1.005	1.0115	1.023238	1.027
10/31	1.07767	1.06867	1.06667	1.00208333	1.005	1.0115	1.023238	1.027
11/30	1.07458	1.06833	1.06708	1.00208333	1.005	1.0115	1.023238	1.027
12/31	1.07200	1.06900	1.06750	1.00208333	1.005	1.0115	1.023238	1.027
01/31	1.06900	1.06958	1.06800	1.00208333	1.005	1.0115	1.023238	1.027
02/28	1.06900	1.07167	1.06850	1.00208333	1.005	1.0115	1.023238	1.027
03/31	1.06900	1.07075	1.06900	1.00208333	1.005	1.0115	1.023238	1.027
04/30	1.06900	1.07133	1.06950	1.00208333	1.005	1.0115	1.023238	1.027
05/31	1.06900	1.07197	1.07000	1.00208333	1.005	1.0115	1.023238	1.027
06/30	1.06900	1.07250	1.07050	1.00208333	1.005	1.0115	1.023238	1.027
07/31	1.06900	1.07308	1.07100	1.00208333	1.005	1.0115	1.023238	1.027
08/31	1.06900	1.07667	1.07150	1.00208333	1.005	1.0115	1.023238	1.027

1_/ For fiscal year 1987, the update factor for FY 1986 is deemed to be 1.005.

2_/ For fiscal year 1989, the update factor for FY 1988 is deemed to be 1.027.

Update Factor Table (Cont.)

HOSPITAL FY ENDS	FEDERAL FY 1989 BEGINS 10/1/88	FEDERAL FY 1990 BEGINS 10/1/89	FEDERAL FY 1991 BEGINS 10/1/90	FEDERAL FY 1992 BEGINS 10/1/91	FEDERAL FY 1993 BEGINS 10/1/92	FEDERAL FY 1994 BEGINS 10/1/93
09/30	1.054	1.055	1.053	1.047	1.042	1.043 Minus applicable reduction 4_/
10/31	1.054	1.055	1.053	1.047	1.042	1.043
11/30	1.054	1.055	1.053	1.047	1.042	1.043
12/31	1.054	1.055	1.053	1.047	1.042	1.043
01/31	1.054	1.055	1.053	1.047	1.042	1.043
02/28	1.054	1.055	1.053	1.047	1.042	1.043
03/31	1.054	1.055	1.053	1.047	1.042	1.043
04/30	1.054	1.055	1.053	1.047	1.042	1.043
05/31	1.054	1.055	1.053	1.047	1.042	1.043
06/30	1.054	1.055	1.053	1.047	1.042	1.043
07/31	1.054	1.055	1.053	1.047	1.042	1.043
08/31	1.054	1.055	1.053	1.047	1.042	1.043

Adjustment Factors To Be Applied To Updated Target Amounts For Cost Reporting Periods Beginning On Or After November 1, 1989, And Before January 1, 1991 3_/

Cost Reporting Period	Adjustment Factor
Nov. 1, 1989 to Oct. 31, 1990	.9984
Dec. 1, 1989 to Nov. 30, 1990	.9941
Jan. 1, 1990 to Dec. 31, 1990	.9897
Feb. 1, 1990 to Jan. 31, 1991	.9897
Mar. 1, 1990 to Feb. 28, 1991	.9897
Mar. 1, 1990 to Mar. 31, 1991	.9897
May 1, 1990 to Apr. 30, 1991	.9897
June 1, 1990 to May 31, 1991	.9897
Jul. 1, 1990 to June 30, 1991	.9897
Aug. 1, 1990 to July 31, 1991	.9897
Sep. 1, 1990 to Aug. 31, 1991	.9897
Oct. 1, 1990 to Sep. 30, 1991	.9901
Nov. 1, 1990 to Oct. 31, 1991	.9916
Dec. 1, 1990 to Nov. 30, 1991	.9957

3_/ The factors are applied as follows: ((Updated target amount X program discharges) X (adjustment factor))

4_/ See §3002.B for method of determining applicable reduction

Target Amount Calculation

EXAMPLE: A rehabilitation hospital has a calculated base year (FY 1985) allowable cost of $9,500 per discharge (based on the total Medicare inpatient operating costs, excluding capital and medical education costs, divided by Medicare discharges). To determine the target amount for its cost reporting period beginning in FY 1986, the base year per discharge cost of $9,500 is multiplied by the applicable update factor from the preceding tables (1.00208333), resulting in a FY 1986 target amount of $9,519.79 per discharge.

To calculate the FY 1987 target amount, the base year per discharge cost is multiplied by 1.005, since the FY 1986 update factor is deemed to be .5 percent. (See footnote 1 in the update factor table.) The product of this calculation is then multiplied by the FY 1987 update factor of 1.0115 to arrive at the target amount for fiscal year 1987 of $9,657.30.

FY 1987 target amount:

$ 9,500.00	FY 1985 program operating cost per discharge
X 1.005	FY 1986 update (deemed 0.5 percent)
$ 9,547.50	
X 1.0115	FY 1987 update (1.15 percent)
$ 9,657.30	Target amount for FY 1987

C. Calculating the Ceiling.--The ceiling is determined for a given cost reporting period by multiplying the applicable target amount by the number of Medicare discharges in the cost reporting period.

For purposes of excluded hospitals and units, a discharge is defined as a patient meeting any of the following conditions:

- The patient is formally released from the hospital or unit;
- The patient dies in the hospital or unit; or
- The patient is transferred to another hospital or unit.

However, when Medicare inpatient hospital benefits (including the election to use lifetime reserve days) are exhausted during the inpatient stay, the patient is considered discharged on the date that the Medicare program determines the patient is no longer eligible for Part A inpatient hospital services instead of when the patient is formally released.

1. Inpatient Operating Costs Exceed the Ceiling.--

a. For cost reporting periods beginning on or after October 1, 1982, and before October 1, 1984, 25 percent of the costs in excess of the ceiling are allowable.

b. For cost reporting periods beginning on or after October 1, 1984, and before October 1, 1991, no costs in excess of the ceiling are allowable.

c. For cost reporting periods beginning on or after October 1, 1991, payment is based on the lower of:

o The hospital's ceiling plus 50 percent of the allowable operating costs that exceed the ceiling; or

o 110 percent of the hospital's ceiling.

2. Costs Are Equal to or Less Than Ceiling.--For cost reporting periods beginning on or after October 1, 1982, Medicare pays the hospital's allowable inpatient operating costs plus the lesser of:

o 50 percent of the difference between the allowable inpatient operating costs and the ceiling; or

o 5 percent of the ceiling.

3003. EXEMPTIONS FROM RATE OF INCREASE CEILING

New hospitals that began participation in the Medicare program before October 1, 1992, may request an exemption from the rate of increase ceiling under the provisions of §§3003.1 through 3003.5. These hospitals have 180 days from the date of a final notice of program reimbursement to file a request for an exemption from the rate of increase ceiling with their fiscal intermediary. A new hospital is a hospital that has been operating for less than 3 full years, under current or previous ownership, as the type of hospital for which it received HCFA approval for participation in the Medicare program (as provided in 42 CFR 413.40(f)(1) prior to October 1, 1992).

A newly established unit that is excluded from PPS does not qualify for the new hospital exemption. Risk basis HMOs may request an exemption as provided in 42 CFR 413.40(f)(2). Thus, new hospitals and risk basis HMOs are the only types of providers that may seek an exemption from the rate of increase ceiling.

New hospitals that began participation in the Medicare program on or after October 1, 1992, that meet the criteria in §3003.6 are automatically granted an exemption from the rate of increase ceiling. Effective with hospitals that begin participation on or after October 1, 1992, a new hospital is a provider of hospital inpatient services that:

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

o Has provided the type of hospital inpatient services for which HCFA granted it approval to participate in the Medicare program for less than 2 years.

3003.1 Requesting Exemption.--A hospital that began participating in the Medicare program before October 1, 1992, must include the following information in its request for exemption:

o Name, address, and provider number of the requesting facility;

o General information about the hospital, e.g., type of facility description of the patient population, area served;

o A request for relief on the basis of the provisions in 42 CFR 413.40(f); and

o Effective date of the Medicare provider agreement (tie-in notice) and the date the provider accepted its first patient.

3003.2 Calculating Exemption Period.--For hospitals that were approved for participation in the Medicare program prior to October 1, 1992, the exemption expires at the end of the first cost reporting period that begins at least 2 years after the hospital accepts its first patient.

The base period for a new hospital is the last cost reporting period for which its exemption is applicable, i.e., the first cost reporting period beginning at least 2 years after the hospital accepts its first patient.

EXAMPLE: A rehabilitation hospital admitted its first patient on December 4, 1986, and its Medicare provider agreement was approved effective December 14, 1986. The hospital's fiscal year ends August 31.

December 4, 1986 admitted first patient
\+ 2 years
December 4, 1988

Since the hospital's cost reporting period is September 1 through August 31, the first cost reporting period beginning after December 4, 1988, starts September 1, 1989. Therefore, the hospital is exempt from the target rate of increase ceiling through its cost reporting period that ends August 31, 1990. The cost reporting period ending August 31, 1990, serves as the base period used to establish the target amount used for determining the rate of increase ceiling for future periods.

EXAMPLE: A psychiatric hospital's Medicare provider agreement was approved effective January 8, 1985, and it admitted its first patient on November 28, 1984. The hospital's fiscal year ends December 31.

November 28, 1984 admitted first patient
\+ 2 years
November 28, 1986

The first cost reporting period beginning after November 28, 1986, is the cost reporting period beginning January 1, 1987, and ending December 31, 1987. The hospital could be exempt from the target rate of increase ceiling through this cost reporting period. The cost reporting period ending December 31, 1987, also serves as the base year used to establish the rate per discharge used for determining the rate of increase ceiling for future periods.

EXAMPLE: An acute care hospital's Medicare provider agreement was approved in 1984. On May 1, 1990, the hospital was reclassified as a rehabilitation hospital and admitted its first patient as a rehabilitation hospital. The hospital's fiscal year ends December 31.

May 1, 1990 admitted first patient
+ 2 years
May 1, 1992

The rehabilitation hospital qualifies as a new provider and could be exempt from the rate of increase limits since it has operated for fewer than 3 years as the type of provider (rehabilitation hospital) for which it has been approved for Medicare participation. Since the first cost reporting period beginning after May 1, 1992, is the cost reporting period ending December 31, 1993, the hospital is exempt from the rate of increase ceiling through this cost reporting period. The cost reporting period ending December 31, 1993, also serves as the base year used to establish the cost per discharge used in determining the rate of increase ceiling applicable to future periods.

3003.3 Intermediary Role.--When the intermediary receives an application for exemption from the rate of increase ceiling from a hospital that began participation before October 1, 1992, the intermediary reviews the application for completeness and requests any additional information within 60 days. The intermediary evaluates the hospital's request and verifies the supporting documentation. Within 75 days from the date of receipt of a completed application, the intermediary verifies and attests to the fact that the provider either meets or does not meet the requirements in §3003 for an exemption from the rate of increase ceiling and forwards its recommendation for a final decision to HCFA.

3003.4 HCFA's Review and Decision.--Upon receiving the information and recommendation from the intermediary, HCFA:

- Reviews the entire package as submitted by the intermediary;

- Requests additional information from the intermediary when the intermediary's recommendation is not supported by sufficient documentation; and,

- Makes a decision based on the material submitted and advises the intermediary in writing of the decision no later than 180 days from the date the completed application and the intermediary's recommendation are received by HCFA. The decision letter includes a detailed explanation of the reasons for approval or disapproval of the hospital's request.

NOTE: The 180 day time limit does not include the days between the day additional information needed to process the application was requested by HCFA and the day that information was received.

Upon receipt of HCFA's determination, the intermediary informs the hospital of HCFA's determination and takes appropriate action to implement the decision.

3003.5 Review of Determination.--A hospital may request a review of the determination based on the submission of additional information. The hospital must submit the review request and additional information to its intermediary within 180 days of the date of the letter notifying the hospital of the original decision.

The intermediary verifies the additional information and forwards the review request to HCFA within 75 days. HCFA notifies the intermediary of its decision on the request within 180 days of receiving the request from the intermediary.

3003.6 Automatic Exemption from Rate of Increase Ceiling.--Effective October 1, 1992, new hospitals that meet all of the following criteria are automatically exempted from the rate of increase ceiling:

o The hospital's Medicare provider agreement was approved effective on or after October 1, 1992;

o The hospital has operated as the type of hospital for which it was certified for participation, under present and previous (if applicable) ownership, for fewer than 2 full years; and

o The hospital has provided the type of inpatient services for which it was approved for fewer than 2 full years.

A. Determining Eligibility for Exemption.--A hospital that has not previously provided inpatient services of any nature and is approved for participation in the Medicare program on or after October 1, 1992, is automatically exempted from the rate of increase ceiling.

EXAMPLE: A new psychiatric hospital is accredited by the Joint Commission on Accreditation of Healthcare Organizations and applies for and is approved for participation on November 17, 1992. The hospital is automatically exempted from the rate of increase ceiling.

A hospital may have been providing inpatient services prior to its approval for participation in the Medicare program and still qualifies as a new hospital.

EXAMPLE: A rehabilitation hospital is accredited and admits its first patient on August 28, 1991. It applies for and is approved for participation effective December 12, 1992. Since the first patient was admitted fewer than 2 years prior to approval, and the hospital was approved after October 1, 1992, the hospital qualifies for exemption.

A hospital that experiences a change in organizational structure (e.g., a freestanding hospital becomes a distinct part unit or vice versa) but continues to provide the same inpatient services (rehabilitation or psychiatric) for which it was approved prior to the organizational change does not qualify for exemption as a new hospital.

EXAMPLE: A PPS hospital with a distinct part rehabilitation unit moves to a new building. The old building is converted to a freestanding rehabilitation hospital and is approved as such for Medicare participation. There has been no change in the services provided or the patient population served. The rehabilitation hospital does not qualify for exemption from the rate of increase ceiling as a new hospital.

B. Calculating Exemption Period.--The exemption from the rate of increase ceiling begins when the hospital accepts its first patient and ends with the first 12 month cost reporting period ending at least 2 years after the date of admission of the first patient.

EXAMPLE: A rehabilitation hospital admitted its first patient on December 4, 1992, and was approved for Medicare participation on December 14, 1992. The hospital's fiscal year ends August 31.

December 4, 1992 admitted first patient
\+ 2 years
December 4, 1994

Since the hospital's cost reporting period is September 1 through August 31, the first 12 month cost reporting period ending after December 4, 1994, is the period of September 1, 1994, to August 31, 1995. Therefore, the hospital is exempt from the target rate of increase ceiling through its cost reporting period that ends August 31, 1995.

C. Determining Base Period.--Effective October 1, 1992, the base period for the rate of increase ceiling is determined as follows.

1. New Hospitals.--The base period for a new hospital that qualifies for exemption from the rate of increase ceiling, as provided in subsection A, is the first 12 month cost reporting period that begins at least 1 year after the hospital accepts its first patient.

EXAMPLE: A new psychiatric hospital qualifies for exemption from the rate of increase ceiling. The hospital admitted its first patient on April 4, 1993. Its fiscal year is July 1 through June 30. The hospital's base period is the July 1, 1984, through June 30, 1985, cost reporting period (the first 12 month period beginning at least 1 year after the first patient was admitted).

EXAMPLE: A new acute care hospital admits its first patient on November 7, 1992. At the end of its first full cost reporting period, January 1 through December 31, 1993, during which the hospital had an average length of stay in excess of 25 days, the hospital changes its participation status to long term hospital. Since the hospital has been serving a patient population requiring long term inpatient care from the outset, its base period is the first 12 month cost reporting period beginning at least 1 year after it admitted its first patient as an acute care hospital. The change in participation entailed no change in either the type of services furnished or the organizational structure of the hospital. Therefore, this hospital's base period is the January 1 through December 31, 1994 cost reporting period.

2. Hospitals Undergoing Change in Organizational Structure.--A participating hospital that reorganizes (for example, from an excluded hospital to an excluded unit of an acute care hospital) but continues to provide the same services as it did before the reorganization does not qualify for exemption from the rate of increase ceiling as a new hospital. A hospital undergoing change in organizational structure does not incur the significant patient care cost distortions associated with being a new hospital. Any cost distortions that affect the comparability of cost reporting periods stem from a change in the organizational structure of the facility rather than in the type of services it provides to patients.

However, the ceiling that applied before the hospital's reorganization might not appropriately reflect costs after its reorganization. Therefore, to account for the effect of changes in the operational structure of the hospital or distinct part unit (that is, a freestanding rehabilitation hospital becomes a distinct part unit or vice versa (see 42 CFR 413.40(b)(1)(iii)) on operating costs per discharge, the base period is the first full 12 month cost reporting period following the effective date of the revised Medicare certification classification.

EXAMPLE: A PPS hospital with a distinct part rehabilitation unit moves to a new building. The old building is converted to a freestanding rehabilitation hospital and receives Medicare approval as such on November 18, 1992. The rehabilitation hospital's fiscal year is January 1 through December 31. The rehabilitation hospital's base period is the January 1 through December 31, 1993, cost reporting period.

This provision does not apply to organizational changes that occur as a consequence of a change in ownership of an excluded hospital or unit. Alterations of the supervisory or managerial structure of a hospital are made on the initiative and are totally under the control of management. To the extent that such changes entail an increase in cost per discharge, it is incumbent upon prudent management to implement changes in other aspects of the hospital's operation to offset the increased costs.

D. Notification of Exemption.--Within 75 days of receipt of a tie-in notice from the RO, the intermediary determines if the excluded hospital qualifies for exemption. The intermediary notifies the hospital of its exempt status and which fiscal year will be its base period.

3004. ADJUSTMENTS TO RATE OF INCREASE CEILING

Due to a variety of circumstances, inpatient operating costs of a hospital or unit could exceed the ceiling in one or more cost reporting periods. If these excess costs are reasonable, justified, and directly related to patient care services, the provider may request an adjustment to the payment allowed under the rate of increase ceiling. Hospitals have 180 days from the date of a final notice of program reimbursement to request an adjustment to the payment allowed under the rate of increase ceiling from the intermediary. The premise underlying the rate of increase ceiling is that inpatient operating costs remain comparable from year to year absent any significant change in services or patient population. Changes in the type of patients served or in patient care services that distort the comparability of a cost reporting period to the base year are grounds for an adjustment request. A hospital may request an adjustment to the payment allowed under the rate of increase ceiling in situations where there is a distortion in a hospital's operating costs in either its base period or a cost reporting period subject to the ceiling. HCFA makes such an adjustment at the hospital's request only under the following conditions:

- The hospital's allowable inpatient operating costs exceed the ceiling;
- The excess costs are related to direct patient care services;
- The excess costs are attributable to the circumstances specified;
- The excess costs are separately identified by the hospital;

- The excess costs are verified by the intermediary; and
- The excess costs are determined to be reasonable.

The intermediary or HCFA may also initiate adjustments without the provider's request to take into account cost distortions between the base year and the current year. These specific adjustments include, but are not limited to, adjustments that take into account:

- FICA taxes (if the hospital did not incur costs for FICA taxes in its base year);
- Services billed under Part B of Medicare during the base period but paid under Part A during the subject cost reporting period;
- Malpractice insurance costs (if malpractice insurance costs were not included in the base year operating costs);
- 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; and
- The manipulation of discharges to increase reimbursement.

3004.1 Basis For Adjustment.--A hospital may request an adjustment to the payment allowed under the rate of increase ceiling if its costs exceed the ceiling and there are differences in inpatient costs incurred during the cost reporting period in question that make comparison to the base period inappropriate. Distortions in inpatient operating costs resulting in noncomparability of the cost reporting periods are generally the result of extraordinary circumstances or one or both of two factors:

1. Increases in the average length of stay of Medicare patients, and/or
2. Changes in the volume or intensity of direct patient care services.

NOTE: The calculations illustrated throughout this chapter demonstrate the methodology the intermediaries and HCFA use to calculate the adjustments indicated. Without the information reflected in a particular calculation, the adjustment request cannot be processed. The following are examples of situations most commonly found as the factors causing a hospital to exceed its ceiling. A hospital is not precluded, however, from submitting and documenting other factors related to patient care services that contributed to its costs per discharge exceeding the target amount as long as these factors are substantiated with documentation that quantifies the financial effect relative to its Medicare inpatient operating costs per discharge in the current cost reporting period compared to its base year.

A. Extraordinary Circumstances.--These circumstances include, but are not limited to, fire, earthquakes, floods, or similar unusual occurrences causing substantial cost increases in a cost reporting period. A provider may request an adjustment to the rate of increase ceiling for the cost reporting period(s) affected by such circumstances that are beyond the provider's control.

B. Increase in Average Length of Stay of Medicare Patients.--If an increase in the average length of stay of Medicare patients over that of the base year is the cause of the excess costs, the reasons contributing to the length of stay increase must be established and documented. Common causes for increases in length of stay are:

- o Increased medical acuity;
- o Changes in admission practices or criteria;
- o Changes in types of patients served; and
- o Changes in practice patterns.

The reasons for a length of stay increase must be substantiated with supporting documentation, e.g., differences in the number of cases per diagnosis and their length of stay in the base year as compared to the applicable cost reporting period.

EXAMPLE: A rehabilitation hospital exceeds its ceiling for the cost reporting period ending December 31, 1986, and requests a payment adjustment. The provider cites an increase in its Medicare average length of stay from 33 days in its base year (1984) to 36 days in the cost reporting period ending December 31, 1986, as justification for the cost increase. As documentation for this claim, the provider submits data indicating earlier discharges from acute care hospitals to the rehabilitation facility in 1986. The provider also submits documentation comparing the functional status scores of the patient population between the two cost reporting periods.

The intermediary verifies the hospital's documentation and reviews the cost reports from the base year and 1986 cost reporting periods to assure that the cost in excess of the target amount did not result from increases in cost in areas unrelated to an increase in the average length of stay of Medicare patients. The intermediary then calculates an adjustment as follows.

Adjustment Methodology For Increases In Average Length Of Stay (ALOS)

Since the rate of increase ceiling is based on an average cost per discharge, the impact of the increase in the average length of stay of Medicare patients is measured by converting the target amount from a per discharge limit to a limit based on a per diem rate. The amount of the adjustment is limited to the lesser of the difference between the ceiling based on the per discharge target amount and one based on the per diem target amount or the operating costs that exceed the ceiling based on the per discharge target amount. The following example illustrates the methodology for determining an adjustment for a hospital's FY 1986 cost reporting period.

1.	FY 1986 Medicare days	4,863
2.	Target amount converted into a per diem limitation:	
	a. FY 1986 per discharge target amount of $10,322.84 x 90 (base year Medicare discharges)	$ 929,056
	b. $929,056 ☐ 2806 (base year Medicare days)	$ 331.10
3.	Revised ceiling based on per diem rate (line 1 X line 2b)	$ 1,610,139
4.	Ceiling based on a per discharge rate (from Supplemental Worksheet D-1)	$ 1,527,780
5.	Difference between per diem and per discharge ceilings (line 3 - line 4)	$ 82,359
6.	Disallowance based on a per discharge target amount (from Supplemental Worksheet D-1)	$ 509,364
7.	ALOS adjustment (lesser of line 5 or line 6)	$ 82,359

C. Increase in Costs of Direct Patient Care Services.--A variety of factors can cause an increase in the cost per patient day of direct patient care services as compared to the base year. Serving a different patient population than in the base year may require the delivery of more services per patient, the hiring of additional staff, an upgrading of staff skill level, or the addition of new services. The change in the patient population must be documented and its effect on the hospital's inpatient operating costs must be quantified.

Adjustment calculations differ slightly depending on whether there has been an ALOS increase. If the ALOS has increased, the ALOS calculation is done first to determine the increased costs that are accounted for in the ALOS adjustment.

1. Increased Routine Service Intensity.--To calculate an adjustment for increased staffing, determine Medicare's share of general routine costs in the base year target amount. Compute a total average salary and employee benefit cost per full time equivalent employee (FTE) in the base year. The total average salary and employee benefit cost per FTE in the base year is then multiplied by the number of FTEs in the cost reporting period in question to impute an adjusted general routine service salary cost. This methodology limits salary increases to the target amount percentage increases. The adjustment is based on the lesser of Medicare's share of actual general routine service costs in the year under appeal or the imputed general routine service costs.

If a hospital experiences a change from the base year in the mix of skill levels of its nursing staff, the change could also be grounds for an adjustment if documented and justified. The hospital must submit data indicating nursing hours or FTE levels and nursing salaries by job classification in the base year as well as the year under appeal in order to determine the effect of the change in skill mix on average salary and employee benefit cost per FTE and whether an adjustment is warranted.

EXAMPLE: A psychiatric facility experiences a significant increase in the medical acuity of its patient population and exceeds the rate of increase ceiling applicable to its FY 1987 cost reporting period because of an increase in the intensity of nursing services as well as increased Medicare patient ALOS. The hospital hires additional nursing staff at higher skill levels to meet the increased demands of its patients. A listing of the number of cases per diagnosis in the base year compared to FY 1987 indicates that the facility was serving a patient population with greater patient needs than in the base year.

Having substantiated that the facility was serving a patient population requiring more patient care and that additional nursing staff was necessary, the provider demonstrated the impact that hiring the additional nursing staff had on its inpatient operating costs. After the payment adjustment for increased Medicare patient ALOS, the hospital still had costs in excess of its target amount.

Adjustment Methodology for Increased Staffing
With Increased Medicare ALOS
(Lines 4 and 5 must be completed only when
Medicare ALOS increases)
FYE 08/31/88
Routine Costs

1. Base year Medicare inpatient operating costs excluding pass through costs $ 800,000

2. Base year Medicare discharges 250

3. Base year Medicare average cost per discharge updated ((line 1 ☐ line 2) X (appropriate update factors))
(1.069 X 1.07667 X 1.0715 X 1.005 X 1.0115) $ 4,011.76

4. ALOS increase adjustment factor (Medicare appeal year ALOS ☐ base year Medicare ALOS) (35.55 ÷ 31.02) 1.14603

5. Base year Medicare average cost per discharge adjusted for ALOS increase (line 3 X line 4) $ 4,597.62

6. Base year adult & pediatric salaries plus employee benefits (EB) per FTE (Total salaries must tie to the base year cost report.)

	A Salaries	X	B Worksheet B-1 EB Unit Cost Multiplier + 1	=	C Salaries	÷	D FTE(s)	=	
a) RNs	$ 73,043	X	1.150000	=	$ 84,000	÷	4	=	$ 21,000
b) LPNs	$109,565	X	1.150000	=	$126,000	÷	7	=	$ 18,000
c) Aides	$208,696	X	1.150000	=	$240,000	÷	15	=	$ 16,000
d) Cler.	$ 32,609	X	1.150000	=	$ 37,500	÷	3	=	$ 12,500

7.	Base year payroll cost at current year FTE levels		
	a. RNs 7 X $21,000		
	b. LPNs 11 X $18,000		
	c. Aides 16 X $16,000		
	d. Clerical 4 X $12,500		$ 651,000
8.	Base year operating costs other than salaries and employee benefit costs (Worksheet B, Part I - pass through costs - line 6 above, column C)		$ 295,374
9.	Base year other costs adjusted for utilization ((line 8 ÷ base year total days) X (appeal year total days))		$ 367,336
10.	Base year adjusted total costs updated ((line 7 + line 9) X appropriate update factor)		$1,276,661
11.	Appeal year total costs excluding pass through costs (Total costs from Worksheet B, Part I - pass through costs from Worksheet B, Part II)		$1,508,943
12.	Appeal year total inpatient days		5,000
13.	Average cost per day ((lesser of line 10 or line 11) ÷ (line 12))		$ 255.33
14.	Appeal year Medicare inpatient days		3,960
15.	Imputed Medicare inpatient costs (line 13 X line 14)		$1,011,107
16.	Appeal year adjusted Medicare average cost per discharge (line 15 ÷ 208 (appeal year Medicare discharges))		$ 4,861.09
17.	Excess cost justified (line 16 - line 5) X 208 (appeal year Medicare discharges)) Enter 0 if the result is negative.		$ 54,802
18.	Cost in excess of ceiling (from Supplemental Worksheet D-1 less adjustment for increased ALOS)		$ 120,000
19.	Payment adjustment (lesser of line 17 or line 18)		$ 54,802

2. Increased Ancillary Service Intensity With Increased ALOS and No Additional Staffing.--

EXAMPLE: A rehabilitation facility experiences an increase in patients with physical disabilities. As a result, utilization of laboratory services increases. The hospital demonstrates that the increased laboratory cost is attributable to increased patient medical acuity.

NOTE: For ancillary service payment adjustments, the inpatient days used in steps 7 and 8 are the sum of all inpatient days for all inpatient service areas of the hospital that generate ancillary service charges. These areas include adults and pediatrics, intensive care, all subproviders, SNF, ICF, other long term care, and hospice, as applicable.

Adjustment Methodology Without an Increase in Staffing
(Lines 4 and 5 must be completed only when
Medicare ALOS increases)
FYE 06/30/88
Laboratory

1.	Base year Medicare inpatient costs excluding pass through costs	$ 35,000
2.	Base year Medicare discharges	130
3.	Base year Medicare average cost per discharge updated ((line 1 ÷ line 2) X (appropriate update factors)) (1.069 x 1.0725 x 1.0705 x 1.005 x 1.0115)	$ 335.91
4.	ALOS increase adjustment factor (Medicare appeal year ALOS ÷ base year Medicare ALOS) (24.26 ☐ 22.58)	1.074402
5.	Base year Medicare average cost per discharge adjusted for ALOS increase (line 3 X line 4)	$ 360.90
6.	Base year total costs excluding pass through costs (From Worksheet B, Part I - pass through costs)	$2,345,636
7.	Base year total inpatient days (hospital routine days + subprovider days)	73,306
8.	Appeal year total inpatient days	71,546
9.	Base year total costs adjusted for utilization (line 6 ÷ line 7) X (line 8)	$ 2,289,320
10.	Base year adjusted total costs updated (line 9 X appropriate update factors)	$ 2,856,276
11.	Appeal year total costs excluding pass through costs (Total costs from Worksheet B, Part I - pass through costs from Worksheet B, Part II)	$ 2,923,302
12.	Appeal year total charges	$ 3,603,173
13.	Cost to charge ratio ((lesser of line 10 or line 11) ÷ (line 12))	.797711
14.	Appeal year Medicare inpatient charges	$ 110,472
15.	Imputed Medicare inpatient costs (line 13 X line 14)	$ 87,572
16.	Appeal year adjusted average cost per discharge (line 15 ÷ 160 (appeal year Medicare discharges))	$ 547.33
17.	Excess cost justified ((line 16 - line 5) X 160 (appeal year Medicare discharges)) Enter 0 if the result is negative.	$ 29,829
18.	Cost in excess of ceiling (From Supplemental Worksheet D-1 less adjustment for increased ALOS)	$ 79,829
19.	Payment adjustment (lesser of line 17 or 18)	$ 29,829

3. Increased Ancillary Service Intensity with Increased ALOS and Additional Staffing.--

EXAMPLE: The rehabilitation facility in subsection C.2 also experiences an increase in utilization of medically necessary physical therapy services. The increase in demand is such that the hospital must increase employment in the physical therapy department. While the ratio of therapists to aides to clerks does not change, total employment increased from 23 to 26 FTE employees.

Adjustment Methodology For Increased Staffing
(Lines 4 and 5 must be completed only when
Medicare ALOS increases)
FYE 06/30/88
Physical Therapy

1.	Base year Medicare inpatient costs excluding pass through costs	$ 210,000
2.	Base year discharges	130
3.	Base year Medicare average cost per discharge updated ((line 1 ÷ line 2) X (appropriate update factors))	$ 2,015.44
4.	ALOS increase adjustment factor (Medicare appeal year ALOS ☐ base year Medicare ALOS)	1.074402
5.	Base year Medicare average cost per discharge adjusted for ALOS increase (line 3 X line 4)	$ 2,165.39
6.	Base year Physical Therapy salaries plus fringe benefits per FTE	
	A B C D $652,174 X 1.150000 = $750,000 ÷ 23 =	$ 32,608.70
7.	Base year payroll cost at current year FTE levels (line 6 X 26)	$ 847,826
8.	Base year other than salaries and employee benefit costs (from Worksheet B, Part I - pass through costs - line 6C above)	$ 325,000
9.	Base year other costs adjusted for utilization (line 8 ÷ base year total days) X (appeal year total days) (line 8 ÷ 73,306) X 71,546	$ 317,197
10.	Base year total costs updated ((line 7 + line 9) X appropriate update factors)	$ 1,453,544
11.	Appeal year total costs excluding pass through costs (Total costs from Worksheet B, Part I - pass through costs from Worksheet B, Part II)	$ 1,500,000
12.	Appeal year total charges	$ 1,834,682
13.	Cost to charge ratio ((lesser of line 10 or line 11) ÷ (line 12))	.792259

14.	Appeal year Medicare inpatient charges	$ 516,000
15.	Imputed Medicare inpatient costs (line 13 X line 14)	$ 408,806
16.	Appeal year adjusted average cost per discharge (line 15 ÷ 160 (appeal year Medicare discharges))	$ 2,555.04
17.	Excess cost justified ((line 16 - line 5) X (appeal year Medicare discharges)) Enter 0 if the result is negative	$ 62,344
18.	Cost in excess of ceiling (From Supplemental Worksheet D-1)	$ 50,000
19.	Payment adjustment (lesser of line 17 or 18)	$ 50,000

NOTE: The cost in excess of the ceiling (line 18) has been reduced by the $29,829 payment adjustment allowed in Example 3, above, as well as the adjustment for increased ALOS.

4. Addition/Deletion of Services.--A provider adding a new service could incur increased costs due to a variety of factors, e.g., increased staff or upgrading of staff skill level. If the hospital's costs exceed its ceiling, the addition of a new service could warrant a permanent adjustment to the TEFRA target amount for the first 12 month cost reporting period in which the service was provided in all 12 months and cost reporting periods subsequent to it. Similarly, any deletion of services warrants a permanent change to the TEFRA target amount.

EXAMPLE: A rehabilitation hospital requested an adjustment to its rate of increase ceiling for 1987 because, in 1987, the facility exceeded its ceiling as a result of an increase in average length of stay, increased physical therapy services, and the addition of new services.

No costs were reflected in the operating room or recovery room cost centers in the base year cost report but, in 1987 (the first year in which these services were provided in all 12 months), the costs were $73,261 and $64,833, respectively.

A permanent adjustment to the TEFRA target amount was made for the operating room and recovery room services not included in the base year target amount. This adjustment is included in TEFRA target amount calculations for all cost reporting periods subsequent to 1987.

The calculation below demonstrates the methodology for determining the total adjustment due the rehabilitation facility for 1987 and demonstrates the permanent revision to the target amount upon which the subsequent years' target amount is based. This amount is limited to the lesser of the original target amount plus the cost per discharge of the added services or the hospital's current operating cost per discharge.

Part I

Methodology For Adjustment To Allowable Inpatient Operating Costs Due To Additional Services (FY 1987)

1.	FY 1987 total Medicare inpatient operating costs excluding pass through costs (year for which adjustment is requested)	$3,200,000
2.	Adjustment for Medicare operating room costs not included in base year target amount	$ 73,261
3.	Adjustment for Medicare recovery room costs not included in base year target amount	$ 64,833
4.	Adjustment for increased ALOS	$ 71,000
5.	Adjustment for increased ancillary services	$ 92,000
6.	Adjusted Medicare program inpatient operating cost (line 1 minus sum of lines 2 through 5)	$2,898,906
7.	FY 1987 rate of increase ceiling	$2,935,123
8.	Adjusted allowable inpatient operating costs [(lesser of line 6 or line 7) plus lines 2 through 5]	$3,200,000
9.	Allowable inpatient operating costs excluding pass through costs before adjustment (per cost report)	$2,935,123
10.	Adjustment due hospital (line 8 minus line 9)	$ 264,877

Part II

Permanent Revised Target Amount Calculation Due To Additional Services (FY 1987)

1.	Lesser of Part I, line 7 plus lines 2 and 3, or line 8	$3,073,217
2.	Revised FY 1987 target amount (($3,073,217 ÷ 394) (FY 1987 discharges))	$ 7,800.04
3.	FY 1988 rate of increase	1.023238
4.	Revised FY 1988 target amount ($7,800.04 X 1.023238)	$ 7,981.30

5. Ancillary Service Costs for Which There Were No Medicare Charges in the Base Year.--A hospital may request a payment adjustment on the basis that there are Medicare charges for an ancillary service(s) in the current year for which there were no charges in the base year. This is not the addition of a new service, as discussed in the preceding subsection, but rather ancillary service costs in the current year that are not reflected in the base year Medicare cost. Therefore, a payment adjustment is calculated for each

ancillary service for each year in which the situation occurs. The intermediary uses the lower of base year total costs adjusted for utilization and updated or current year total costs to determine the amount of the payment adjustment.

EXAMPLE: A rehabilitation unit has Medicare charges for electrocardiology in the current year. There were no Medicare charges for this ancillary service in the base year.

Adjustment Methodology For Ancillary Services
For Which There Were No Medicare Charges
In The Base Year
FYE 06/30/88
Electrocardiology

1.	Base year total costs excluding pass through costs (from Worksheet B, Part I - pass through costs)	$ 500,000
2.	Base year total inpatient days (hospital routine days + subprovider days)	73,306
3.	Appeal year total inpatient days	71,546
4.	Base year total costs adjusted for utilization (line 1 ÷ line 2) X (line 3)	$ 487,996
5.	Base year adjusted total costs updated (line 4 X appropriate update factors) (1.069 X 1.0725 X 1.0705 X 1.005 X 1.0115)	$ 608,849
6.	Appeal year total costs excluding pass through costs (from Worksheet B, Part I - pass through costs)	$ 653,000
7.	Appeal year total charges	$ 800,000
8.	Cost to charge ratio ((lesser of line 5 or line 6) ÷ (line 7)	.761061
9.	Appeal year Medicare inpatient charges	$ 25,000
10.	Imputed Medicare inpatient costs (line 8 X line 9)	$ 19,027
11.	Cost in excess of target amount (from Supplemental Worksheet D-1)	$ 103,000
12.	Payment adjustment (lesser of line 10 or 11)	$ 19,027

D. Increase in Costs Only Partly Attributable to Patient Care Services.-In cases where cost increases are only partly caused by factors related to direct patient care services, an adjustment is made only for cost increases attributable to factors related to direct patient care.

EXAMPLE: An excluded unit needs to increase its nursing services due to a more medically acute patient population requiring more care. This occurs in a cost reporting period in which the unit also exceeds its ceiling. The hospital believes the increase in services is the cause of the excess costs and so stipulates in the application. Review of the application and cost reports, however, indicates that although the unit provided more nursing services, the overhead costs that the hospital allocated to the unit had also increased substantially over the same period for reasons unrelated to the increase in patient needs.

In this situation, the unit is granted an adjustment to cover higher nursing costs per day but the methodology employed, as shown in §3004.1C, calculates the adjustment based only on those factors directly related to increased nursing services, not on the allocation of increased overhead costs to the unit.

E. Significant Wage Increases.--For cost reporting periods beginning on or after April 1, 1990, an adjustment may be made when a hospital's wages have increased, in the period between its base year and the adjustment year, at a rate in excess of the rate of increase in the national average hourly wage accounted for by the update factor. The hospital's intermediary has the authority to determine whether an adjustment is warranted based on the factors set forth below. The intermediary determines the adjustment amount for significant wage increases using the methodology demonstrated in the following example.

1. Qualifying Areas.--To qualify for a significant wage increase adjustment, a hospital must be located in a geographic area (without regard to any geographic reclassification under §1886(d)(8) and (10) of the Act) where there has been an 8.0 percent or greater increase between:

o The hospital wage index value based on the latest applicable wage data and the hospital wage index value based on 1982 wage data; or

o For hospitals whose base period begins in FY 1984 or later, the wage index value based on the latest applicable wage data and the wage index value based on 1984 wage data.

The latest applicable wage data used to construct the hospital wage index is used in all cases for this comparison. The labor market areas that have had hospital wage index value increases in excess of 8 percent are listed in Exhibit 1 (See 58 FR 46454 dated September 1, 1993. This list of labor market areas is updated annually and produced in the Federal Register Medicare Program; Final Rule.)

Area	1982-1990 Percentage Difference	1984-1990 Percentage Difference	1988-1990 Percentage Difference
Rural Connecticut		21.008	23.410
Rural Hawaii		20.984	11.094
Rural Maryland		8.298	
Rural Massachusetts	17.936	21.776	
Rural New Hampshire		9.265	

Area	1982-1990 Percentage Difference	1984-1990 Percentage Difference	1988-1990 Percentage Difference
Rural Puerto Rico			26.493
Aguadilla, PR		20.475	20.976
Albany, GA		9.126	
Alexandria, GA		8.018	10.431
Ann Arbor, MI		11.235	13.051
Bergen-Passaic, NJ			9.840
Boston-Lowell-Brockton Lawrence-Salem, MA		9.785	
Bridgeport-Stamford-Norwalk Danbury, CT		10.518	
Burlington, NC		8.423	
Caguas		19.104	
Charlotte-Gastonia-Rock Hill, NC-SC	8.274	15.347	
Decatur, AL		8.207	
El Paso, TX			9.447
Florence, SC	13.823	12.656	
Greensboro-Winston-Salem-High Point, NC		9.325	
Hartford-Middleton-New Britain, CT		10.032	
Hickory, NC		8.487	
Houma-Thibodaux, LA			8.756
Killeen-Temple, TX	15.947		
Knoxville, TN		12.229	
Las Cruces, NM			12.784
Macon-Warner Robins, GA		24.478	10.225
Manchester-Nashua, NH	11.187	12.561	
Mayaguez, PR		12.354	13.107
McAllen-Edinburg-Mission, TX		10.757	10.140
Middlesex-Somerset-Hunterdon, NJ		9.810	
Monmouth-Ocean, NJ			9.503
Nassau-Suffolk, NY		11.597	
New Bedford-Fall River-Attleboro, MA	10.877	13.672	
New Haven-West Haven-Waterbury, CT	8.376	12.593	
New London-Norwich, CT		8.033	
Newark, NJ		9.900	
Omaha, NE-IA			10.359
Orange County, NY	10.959	15.011	
Orlando, FL		8.176	
Pine Bluff, AR	9.779	9.160	10.712
Pittsfield, MA	8.333		
Ponce, PR			9.466
Portsmouth-Dover-Rochester, NH	8.979		
Poughkeepsie, NY		9.303	
Providence-Pawtucket-Woonsocket, RI		10.139	
Redding, CA		17.503	10.181
Riverside-San Bernardino, CA			8.684
Sante Fe, NM			9.271
Victoria, TX	9.791	8.340	
West Palm Beach-Boca Raton-Delray Beach, FL		8.361	
Wilmington, NC		11.530	
Worcester-Fitchburg-Leominster, MA		11.702	
Yuma, AZ			8.242

2. Calculating Adjustment Amount.--The adjustment amount is determined by the following factors:

- The hospital's average hourly wage,
- The rate of increase in the average hourly wage for hospital workers in the labor market area, and
- The rate of increase in the national average hourly wage for hospital workers.

The adjustment is limited to the amount by which the lower of the hospital's or the labor market area's rate of increase in average hourly wages exceeds the national increase by more than 8 percent.

The rate of increase for national hourly wages is determined by using the average hourly earnings (AHE) component of the wages and salaries portion of the market basket. The AHE for hospital workers as measured by the market basket show the following increases:

1983 = 8.4 percent
1984 = 5.6 percent
1985 = 5.4 percent
1986 = 4.1 percent
1987 = 4.7 percent
1988 = 6.5 percent
1989 = 6.9 percent
1990 = 5.6 percent
1991 = 5.6 percent
1992 = 4.8 percent
1993 = 4.2 percent
1994 = 4.8 percent

Step 1.--Compare the hospital's actual rate of increase in average hourly wages to the rate of increase in average hourly wages in the labor market area. The hospital's rate of increase is calculated by dividing the difference between its average hourly wage in the year for which the adjustment is requested and its average hourly wage in its base year by its average hourly wage in the base year. The rate of increase in the labor market area is computed by multiplying the cumulative percentage increase in the AHE for hospital workers by the applicable percentage change in the wage index. The lower of the two rates of increase is used in step 3.

Step 2.--Determine the threshold for the adjustment. The threshold is equal to the cumulative percentage increase in the AHE for hospital workers during the period in question multiplied by 1.08.

Step 3.--Subtract the amount determined in step 2 from the lower of the two amounts determined in step 1. This result is the percentage increase that is considered significantly above the increase that is accounted by the update factor.

Step 4.--Determine the proportion of the hospital's operating costs that is attributable to wages and fringe benefits. Adjust this proportion of the hospital's target amount to account for the wage increase by multiplying it by the percentage increase determined in step 3.

As with other adjustments, the adjustment is made only to the extent that the hospital's costs are in excess of the ceiling.

NOTE: The portion of the target amount that is adjusted for significant wage differences includes the components of cost that comprise the labor related portion of the target amount as defined in the hospital market basket. This includes, in addition to the hospital's wage and fringe benefit costs, costs for contract labor (exclusive of payments for supplies and equipment), other professional fees, and payments for business computer services and blood services.

EXAMPLE: A rehabilitation hospital located in Boston, Massachusetts is requesting an adjustment for its 1990 cost reporting period. Since the 1984 base period, its average hourly wage increased from $8.00 to $12.63. The hospital's salaries, fringe benefits, and payments for contract labor and computer services constitute 75 percent of its operating costs. In FY 1990, its operating costs per case were $8,000 and its target amount prior to adjustment was $7,600.

Step 1:

a. Determine the hospital's actual rate of increase in average hourly wages:

($12.63 - $8.00) ÷ $8.00 = .578 or 57.8 percent

b. Determine the labor market area's rate of increase in average hourly wages by multiplying the national average increase by the rate at which the increase in average hourly wage in the Boston metropolitan statistical area (MSA) exceeded the national rate of increase (9.785 percent):

1985 5.4 X 1.09785 = 5.93
1986 4.1 X 1.09785 = 4.50
1987 4.7 X 1.09785 = 5.16
1988 6.5 X 1.09785 = 7.14
1989 6.9 X 1.09785 = 7.58
1990 5.6 X 1.09785 = 6.15

(1.0593 X 1.0450 X 1.0516 X 1.0714 X 1.0758 X 1.0615) = 1.424 or 42.4 percent

Since the rate of increase in the labor market area (42.4 percent) is less than the hospital's rate of increase (57.8 percent), the increase in the labor market area is used in the rest of the calculations.

Step 2: Determine the adjustment threshold by increasing the rate of increase in the national hourly average wage by 8 percent.

5.4 X 1.08 = 5.83
4.1 X 1.08 = 4.43
4.7 X 1.08 = 5.08
6.5 X 1.08 = 7.02
6.9 X 1.08 = 7.45
5.6 X 1.08 = 6.05

(1.0583 X 1.0443 X 1.0508 X 1.072 X 1.0745 X 1.0605 = 1.416 or 41.6 percent)

Step 3: Determine the adjustment to the wage related portion of the ceiling by subtracting the amount determined in step 2 from the lower of the two amounts determined in step 1:

42.4 percent - 41.6 percent = 0.8 percent

Step 4: Determine the adjusted ceiling.

a. Determine the wage related portion of ceiling subject to adjustment.

$7,600 X .75 = $5,700

b. Apply the adjustment determined in step 3 to the wage related portion of the ceiling.

$5,700 X 1.008 = $5,745.60

c. Determine the adjusted ceiling by adding the adjusted wage related portion of the target amount to the nonwage related portion.

$5,745.60 + ($7,600 X .25) = $7,645.60

Since $7,645.60 is less than the hospital's operating costs per case, the full adjustment is authorized.

3004.2 Requesting Adjustment.--A hospital's request for an adjustment to the payment allowed under the rate of increase ceiling must be submitted to its intermediary no later than 180 days from the date on the intermediary's Notice of Program Reimbursement (NPR). The request may be filed once the cost report is submitted.

Most adjustments are made for a particular cost reporting period. Therefore, the hospital must make a separate adjustment request for each affected cost reporting period. There are instances, however, when a permanent adjustment to a hospital's ceiling is approved, i.e., when a new service is added. In these cases, no requests for subsequent cost reporting periods are required.

If the hospital requests a new base period under §3005 and HCFA determines that a new base period is not justified but that an adjustment to the payment allowed is warranted, a new application for relief is not required. HCFA authorizes the adjustment based on the initial request. Similarly, if an adjustment is requested but a new base year is more appropriate, HCFA assigns a new base year without requiring the submittal of another application.

A request must include the following information:

- Name, address and provider number of the requesting facility;
- General information about the hospital, e.g., type of facility description of the patient population, area served;
- Type of relief requested and regulatory basis; i.e., adjustment to target amount under 42 CFR 413.40(g);

o Identification of the source(s) of the higher costs (e.g., higher costs due to additional patient services or to an increase in the average length of stay);

o A demonstration that the higher costs are:

- Above the target amount;

- Reasonable and justified;

- Related to direct patient care services; and,

- Attributable to the circumstances specified;

o Specification and documentation of the factors contributing to the higher costs compared to the base year;

o Documentation and quantification of the direct effect of the contributing factors on Medicare operating costs; and

o An explanation of other significant cost increases since the base period.

To support an increase in service intensity or average length of stay, submit comparative functional status data or diagnosis and length of stay data that substantiate the fact that changes in the patient population have occurred that necessitate the additional services. Submit comparison data on the number and skill level of employees by revenue producing cost center for the base year and the year under appeal to support salary cost increases attributable to increased service intensity. If a new service has been added since the base period, the incremental costs of that service must be identified for the first cost reporting period in which the service was provided throughout the period.

When a variety of factors have caused the hospital's Medicare inpatient operating costs to exceed the target amount, the hospital's request must address each of these factors. For example, a provider could experience a decrease in utilization for one or more cost reporting periods as compared to the base year. This decrease, in combination with other factors, may result in the hospital's Medicare inpatient operating costs exceeding its target amount. A decline in utilization is not a basis for an adjustment. It is expected that as overall utilization decreases, a hospital will take measures to cut costs commensurate with the decline in utilization. The application must discuss these actions, as well as any explanations for any other significant cost increases since the base period, before an adjustment for other factors, e.g., increased service intensity, can be considered.

3004.3 Intermediary Role.--When the intermediary receives an application for relief from the rate of increase ceiling, the intermediary reviews the application for completeness and requests any necessary additional information within 60 days. In its request for additional information, the intermediary may establish a reasonable deadline for the hospital's response. If the hospital has not responded with the requested information by the deadline, the intermediary either forwards the application and its recommendation to HCFA, or (if authorized) makes a final determination on the basis of the information it has received. The intermediary evaluates the hospital's request and verifies the supporting documentation.

After receiving an application for an adjustment to the payment allowed, the intermediary compares the number of discharges, the average length of stay, and inpatient days for all components of the hospital that provide inpatient care between the base year and the year in question for Medicare and non-Medicare patients. In addition, the intermediary compares the hospital's direct and indirect costs and number of employees from the base year to the year for which relief is requested. These comparisons provide general information about changes in the hospital's costs since the base period and the comparisons are used to verify the hospital's claims as to what factors contributed to the excess costs. They also enable a determination as to whether or not other factors not discussed in the application may also have contributed to the increased costs.

The intermediary confirms the hospital's justification for exceeding the rate of increase ceiling and verifies that the hospital's quantification of the higher costs attributable to the documented circumstances is supported by the hospital's cost report data, is consistent with approved methodologies for determining the amount of an adjustment, and that any irregularities are explained fully in the request. The intermediary then forwards the following material to HCFA:

- The provider's application for adjustment (including any supporting documentation);

- Cost reports from the base year and the year in question and, for pre-1984 base years only, the target amount computation (TAC) worksheets;

- For cost reporting periods beginning on and after October 1, 1993, the update factor(s) used to adjust the hospital's target amount.

- An analysis of the hospital's performance for each year from its base year to the year under appeal in the following format;

	Base Year	FY 19	FY 19
Program Discharges			
Net Program Operating Cost			
Target Amount	----		
Amount (Over) Under Target	----		
Incentive Payment	----		

- Worksheets (including discharge, ALOS, and patient days data, when applicable) showing the calculations used to arrive at the amount of relief; and

- The intermediary's recommendation with rationale for approval or disapproval.

Unless HCFA has authorized the intermediary to make the final determination on the request, the intermediary completes its review and forwards its recommendation to HCFA within 75 days of the date of receipt of a completed application.

HCFA may authorize the intermediary to make the final determination on all requests for a specific type of adjustment to the payment allowed under the rate of increase ceiling. For example, the intermediary is authorized to make the final determination on requests for an adjustment based on significant wage increases (See §3004.1E), increases in Medicare patient ALOS (see §3004.1B),

and increased cost attributable to Medicare charges for an ancillary service(s) for which there were no charges in the base year. (See §3004.1C5.) In addition, HCFA may authorize the intermediary to make the final determination for specific hospitals when the circumstances justifying an adjustment in subsequent cost reporting periods are comparable to those in a prior cost reporting period for which HCFA has already approved an adjustment. If HCFA has authorized the intermediary to make the final determination, the intermediary notifies the hospital of its decision within 180 days of receiving the completed application from the hospital. The decision letter includes a detailed explanation of the grounds for approval or disapproval of the adjustment request. If an NPR has not been issued for the cost reporting period, an interim adjustment may be made at the discretion of the intermediary pending final settlement of the cost report.

Once an intermediary has issued a final determination on a request for a payment adjustment, the determination is reported to HCFA. Each report is mailed within 5 working days of the date of the final determination. The form below is used to make the report. An informational copy of the decision letter to the hospital and the calculations are attached to the report.

- The date of request is the date of the first letter from the hospital requesting a payment adjustment. Verbal inquiries are not considered requests. Only a written request signed by an official of the hospital is acceptable.

- If a hospital requests an adjustment for 2 or more fiscal years, a separate form is submitted for each year.

- If a hospital requests an adjustment for more than one subprovider, a separate form is submitted for each of the two subproviders.

- If the adjustment basis is "Other," the intermediary enters the basis on which HCFA has authorized the intermediary to make the final determination.

Excluded Hospitals/Units
TEFRA Payment Adjustment
42 CFR 413.40

Intermediary _____

Name & Phone Number of Contact Person _____

Date of Request _____

Provider Name _____

Address (City, State, Zip Code) _____

Provider or Subprovider Number _____

Type of Provider _____

Adjustment Basis:

└ Increased Medicare Patient Average Length of Stay

└ Significant Wage Increase

└ No Medicare Charges in Base Year

└ Other _____

Fiscal Year From _____ To _____

Program Inpatient Operating Cost Excluding Pass through Cost $ _____

Ceiling Before Adjustment $ _____

Cost over Ceiling $ _____

Amount Requested $ _____

Date of Final Determination _____

└ Denied (Attach copy of letter to hospital) _____

└ Amount Granted (Attach copy of letter to hospital) $ _____

Send To: Health Care Financing Administration
Division of Hospital Payment Policy
1-H-1 East Low Rise
6325 Security Blvd.
Baltimore, Maryland 21207

cc:
Regional Office, Region

3004.4 HCFA's Review and Decision.--Upon receiving the information and recommendation from the intermediary, HCFA:

- o Reviews the entire package as submitted by the intermediary;
- o Requests additional information from the intermediary when the intermediary's recommendation is not supported by sufficient documentation; and
- o Makes a decision based on the material submitted and advises the intermediary in writing of the decision no later than 180 days from the date the intermediary's recommendation is received by HCFA. The decision letter includes a detailed explanation of the reasons for approval or disapproval of the hospital's request.

NOTE: The 180 day time limit does not include the days between the day additional information needed to process the application is requested and the day that information is received.

Upon receipt of HCFA's determination, the intermediary informs the hospital of HCFA's determination and takes appropriate action to implement the decision. For cost reporting periods beginning on and after October 1, 1991, if an adjustment to the ceiling is allowed, the allowable cost in excess of the ceiling (see 3002C1c) must be recalculated before a revised NPR is used.

3004.5 Review of Determination.--A hospital may request a review of the determination based on additional information. The hospital must submit the review request and additional information to its intermediary within 180 days of the date of the letter notifying the hospital of the original decision. If HCFA made the original decision, the intermediary verifies the additional information and forwards the review request to HCFA within 75 days. HCFA notifies the intermediary of its decision on the reconsideration request within 180 days of receiving the request from the intermediary. If the intermediary made the original decision, the intermediary makes the determination on the review request within 180 days of receiving the request from the hospital.

3005. ASSIGNMENT OF NEW BASE PERIOD

Under limited circumstances, a new base period may be assigned if it is determined that the original base period is no longer representative of the reasonable and necessary costs of a hospital's or unit's (used interchangeably in this section) inpatient services. Effective for cost reporting periods beginning on or after April 1, 1990, HCFA may assign a new base period upon a hospital's request if the following conditions are met:

- o The costs exceed the ceiling;
- o The costs are reasonable and justified;
- o Since its base period, the hospital has experienced a permanent, substantial, and significant change in the nature of medically necessary services provided;

- The cost reporting period begins on or after April 1, 1990; and

- The adjustments described in 42 CFR 413.40(g) and §3004 do not result in the recognition of the reasonable and necessary costs of providing inpatient services.

The assignment of a new base period is authorized only under the conditions noted. Financial difficulties or the inability of a hospital to keep within its target amount do not automatically warrant an assignment of a new base period. If a hospital has exceeded its target amount in a cost reporting period due to circumstances noted in §3004, a payment adjustment is authorized. As discussed in §3004.1C4, permanent adjustments to the rate of increase ceiling may be authorized to accommodate the addition or deletion of a service.

A new base period is assigned only if circumstances are such that a hospital substantially changes the nature and focus of services. This may be the case when there has been a significant change in the provision of patient services, e.g., a major change in the type of programs provided by an excluded hospital or unit. It may also occur when significant cost increases have been incurred in order to meet certification or accreditation needs.

The following factors are also taken into consideration when making the determination that a new base year is warranted.

- Changes in applicable technologies and medical practices;

- Differences in the severity of illness among patients or types of patients served; and

- Significant increases in average hourly wages (as determined in §3004.1E).

Since the adjustment mechanism addresses most situations where there is a distortion between the base year and the current period, the circumstances under which the assignment of a new base period is warranted are limited.

3005.1 New Base Period Determination.--The new base period is the first full 12 month or longer cost reporting period that reflects the changes that justified a new base period. For example, if a hospital has a January to December cost reporting period and the substantial changes occurred in March, the new base period is the hospital's subsequent fiscal year.

EXAMPLE: A 10 bed rehabilitation unit with a base period ending December 31, 1983, had provided care that was primarily routine in nature for the repair and rehabilitation of bone fractures and knee and hip replacements. Due to a series of events occurring in the community, the unit was forced, through patient demand, to significantly broaden its provision of services to accommodate head trauma and stroke victims. The unit increased its bed size by 100 percent and hired a wide array of personnel trained in the highly technical skills required to treat these new patients. With the opening of a rehabilitation hospital specializing in bone fractures and replacements in a nearby community, the rehabilitation unit

became highly specialized in head trauma and stroke cases and no longer served bone fracture patients. The unit's average length of stay increased by 50 percent. The type and skill level of staff changed dramatically, and an increase in the number of staff was necessary. The cost per day in the unit increased substantially, resulting in the rehabilitation unit's cost per discharge exceeding its target amount.

In its request for the assignment of a new base period, the rehabilitation unit described and documented in detail all of the changes that had occurred in its provision of services. A description of events in the community precipitating the changes was submitted as well as documentation showing the differences in the unit's services between the current base year and the year in question. This included numbers of staff and skill level, patient diagnoses, average length of stay, and type and amounts of services provided. The intermediary analyzed the submission and recommended that a new base period be assigned, given the permanent, substantial, and significant change in the nature of services provided by the hospital.

The changes occurred in the unit during its cost reporting period ending December 31, 1989. Since the first 12 month cost reporting period beginning after the unit expanded was its cost reporting period ending December 31, 1990, this cost reporting period is used as the hospital's new base period. The ceiling based on the new base period is effective for the hospital's cost reporting period ending December 31, 1991.

Analysis of the cost reports indicated an increase of 75 percent in administrative and general cost while direct costs had increased 35 percent. The indirect cost increase was not discussed in the application nor was documentation submitted to explain the unusually high increase over and above that of direct costs.

The new ceiling was calculated by adding the updated indirect costs reflected in the FY 1990 rate of increase ceiling to the 1991 direct patient care costs and dividing the result by the number of Medicare discharges.

3005.2 Requesting New Base Period.--A hospital's request for the assignment of a new base period must be submitted to its intermediary no later than 180 days from the date on the intermediary's Notice of Program Reimbursement (NPR) for the cost reporting period for which the revised target amount would apply. The request may be filed once the cost report is submitted.

If the hospital requests a new base period and HCFA determines that a new base period is not justified but that a payment adjustment is warranted, a new application for relief is not required. HCFA authorizes the adjustment based on the initial request. Similarly, if an adjustment is requested but a new base year is more appropriate, HCFA assigns a new base year without requiring the submittal of another application.

A request must include the following information:

- Name, address and provider number of the requesting facility;

- General information about the hospital, e.g., type of facility, description of the patient population, area served;

- Type of relief requested and regulatory basis, i.e., new base period under 42 CFR 413.40(i);

- Documentation that demonstrates the hospital has made a permanent, substantial, and significant change in the nature of the services it provides;

- Comparative information about the hospital's services and patient population prior to and after the change;

- An explanation of why the change in patient services occurred;

- A demonstration that the hospital's Medicare inpatient operating costs per discharge exceed the rate of increase ceiling and a quantification of the higher costs that are attributable to the change in patient care services; and

- A discussion of any increases in indirect costs that are in excess of the percentage increase in the rate of increase ceiling and, if applicable, documentation of any excess indirect costs that directly result from the changes in direct patient care services.

3005.3 Inclusion of Indirect Costs in New Base Period.--When indirect costs are not discussed or documented to justify above normal increases, the indirect costs are not included in the new base period calculation beyond the rate of increase percentage increases. Increases in general service cost centers, in and of themselves, may never be the basis for the assignment of a new base period.

In cases where indirect costs have increased above the rate of increase percentages and the hospital describes and documents how the indirect costs are related to the direct patient care cost increases, the new base period reflects these costs. The new base period ceiling is calculated to include the amount of substantiated indirect costs above the rate of increase percentage as well as the direct costs.

3005.4 Intermediary Role.--When the intermediary receives an application for a new base period, the intermediary reviews the application for completeness and requests any additional information within 60 days. In its request for additional information, the intermediary may establish a reasonable deadline for the hospital's response. If the hospital has not responded with the requested information by the deadline, the intermediary either forwards the application and its recommendation to HCFA, or (if authorized) makes a final determination on the basis of the information it has received. The intermediary evaluates the hospital's request and verifies the supporting documentation.

The intermediary compares the number of discharges, the average length of stay, and inpatient days for all components of the hospital that provide inpatient care between the base year and those following, through the year in question, for Medicare and non-Medicare patients. In addition, the intermediary compares the hospital's direct and indirect costs and number of employees from the base

year to the year for which relief is requested. These comparisons provide general information about changes in the hospital's costs since the base period, and they are used to verify the hospital's claims as to what factors contributed to the excess costs. They also enable a determination as to whether other factors, not discussed in the application, may also have contributed to the increased costs.

The intermediary reviews the hospital's justification for a new base period and determines whether the hospital's quantification of the higher costs attributable to the documented circumstances is supported by the hospital's cost report data and that any irregularities are explained fully in the request. The intermediary submits the following material to HCFA:

- o The provider's request and supporting documentation;
- o Cost reports from:
  - The base year;
  - The first full cost reporting period that substantiates the request for a new base period; and
  - If the substantiating year is prior to April 1, 1990, all years subsequent to the substantiating year through the first cost reporting period beginning on or after April 1, 1990;
- o An analysis of the hospital's performance for each year from its base year to the year under appeal in the following format:

	Base Year	FY 19	FY 19
Program Discharges			
Net Program Operating Cost			
Target Amount	----		
Amount (Over) Under Target	----		
Incentive Payment	----		

- o The intermediary's recommendation with rationale for approval or disapproval.

The intermediary completes its review and forwards its recommendation to HCFA within 75 days of the date of receipt of a completed application.

3005.5 HCFA's Review and Decision.--Upon receiving the information and recommendation from the intermediary, HCFA:

- o Reviews the entire package as submitted by the intermediary;
- o Requests additional information from the intermediary when the intermediary's recommendation is not supported by sufficient documentation; and,
- o Makes a decision based on the material submitted and advises the intermediary in writing of the decision no later than 180 days from the date the intermediary's recommendation is received by HCFA. The decision letter includes a detailed explanation of the reasons for approval or disapproval of the hospital's request.

NOTE: The 180 day time limit does not include the days between the day additional information needed to process the application is requested by HCFA and the day that information is received.

Upon receipt of HCFA's determination, the intermediary informs the hospital of HCFA's determination and takes appropriate action to implement the decision.

3005.6 Review of Determination.--If a request for a new base year is denied because of insufficient justification and/or documentation, the hospital may request a review of the determination based on the submission of additional information. The hospital must submit the request and additional information to the intermediary within 180 days of the date of the letter notifying the hospital of the original decision.

The intermediary verifies the additional information and forwards the request to HCFA within 75 days. HCFA notifies the intermediary of its decision on the request within 180 days of receiving the request from the intermediary.

3006. APPEAL RIGHTS

A hospital has the right to appeal to the Provider Reimbursement Review Board (PRRB) the intermediary's determination of the amount of reimbursement due the hospital if the total amount in controversy for its cost reporting period is $10,000 or more. Since a final determination on a request for relief from the rate of increase ceiling affects the amount of program reimbursement, the determination is subject to appeal as part of the NPR (not as a separate appeal).

A request for appeal must be filed with the PRRB in writing within 180 days of the date the NPR is issued. A request for relief from the rate of increase limits under §§3003, 3004, or 3005 is considered good cause to extend the 180 day appeal period. In such instances, the 180 day time frame to file an appeal begins with the date the hospital is notified by its intermediary of either HCFA's denial of an adjustment, provided an NPR has been issued, or with the date of the revised NPR issued after the adjustment determination has been made.

In a situation where a provider with costs in excess of its target does not file for an adjustment within 180 days of the initial NPR and the cost report is subsequently reopened, 42 CFR 405.1889 provides that, following a reopening when an intermediary revises a determination on the amount of program payment, such revision is considered a separate and distinct determination which may be appealed. (See §2926.6 (Appendix A, subsection B2.) A hospital is entitled to appeal only the specific adjustments made by the fiscal intermediary in its revised NPR.