

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 412

[CMS-1588-N]

RIN 0938-AR12

Medicare Program; Extension of the Payment Adjustment for Low-volume Hospitals and the Medicare-dependent Hospital (MDH) Program Under the Hospital Inpatient Prospective Payment Systems (IPPS) for Acute Care Hospitals for Fiscal Year 2013

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Notice of extension.

SUMMARY: This notice announces changes to the payment adjustment for low-volume hospitals and to the Medicare-dependent hospital (MDH) program under the hospital inpatient prospective payment systems (IPPS) for FY 2013 in accordance with sections 605 and 606, respectively, of the American Taxpayer Relief Act of 2012.

DATES: Effective date: [insert date of **filing** in the Federal Register]. Applicability dates: The provisions described in this notice are applicable for discharges on or after October 1, 2012 and on or before September 30, 2013.

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SUPPLEMENTARY INFORMATION:**I. Background**

On January 2, 2013, the American Taxpayer Relief Act of 2012 (ATRA) (Pub. L. 112–240) was enacted. Section 605 of the ATRA extends changes to the payment adjustment for low-volume hospitals for an additional year, through fiscal year (FY) 2013. Section 606 of the ATRA extends the Medicare-dependent hospital (MDH) program for an additional year, through FY 2013.

II. Provisions of the Notice**A. Extension of the Payment Adjustment for Low-Volume Hospitals****1. Background**

Section 1886(d)(12) of the Social Security Act (the Act) provides for an additional payment to each qualifying low-volume hospital under the hospital inpatient prospective payment systems (IPPS) beginning in FY 2005. Sections 3125 and 10314 of the Affordable Care Act provided for a temporary change in the low-volume hospital payment policy for FYs 2011 and 2012. Prior to the enactment of the ATRA, beginning with FY 2013, the low-volume hospital qualifying criteria and payment adjustment returned to the statutory requirements under section 1886(d)(12) of the Act that were in effect prior to the amendments made by the Affordable Care Act. (For additional information on the expiration of the provisions of the Affordable Care Act that amended the low-volume hospital adjustment at section 1886(d)(12) of the Act, we refer readers to the FY 2013 IPPS/LTCH PPS final rule (77 FR 53406 through 53408).) The regulations describing the payment adjustment for low-volume hospitals are at 42 CFR 412.101.

2. Low-Volume Hospital Payment Adjustment for FYs 2011 and 2012

For FYs 2011 and 2012, sections 3125 and 10314 of the Affordable Care Act expanded the definition of low-volume hospital and modified the methodology for determining the payment adjustment for hospitals meeting that definition. Specifically, the provisions of the Affordable Care Act amended the qualifying criteria for low-volume hospitals under section 1886(d)(12)(C)(i) of the Act to specify that, for FYs 2011 and 2012, a hospital qualifies as a low-volume hospital if it is more than 15 road miles from another subsection (d) hospital and has less than 1,600 discharges of individuals entitled to, or enrolled for, benefits under Part A during the fiscal year. In addition, section 1886(d)(12)(D) of the Act, as added by the Affordable Care Act, provides that the low-volume hospital payment adjustment (that is, the percentage increase) is to be determined "using a continuous linear sliding scale ranging from 25 percent for low-volume hospitals with 200 or fewer discharges of individuals entitled to, or enrolled for, benefits under Part A in the fiscal year to zero percent for low-volume hospitals with greater than 1,600 discharges of such individuals in the fiscal year."

We revised the regulations at 42 CFR 412.101 to reflect the changes to the qualifying criteria and the payment adjustment for low-volume hospitals according to the provisions of the Affordable Care Act in the FY 2011 IPPS/LTCH PPS final rule (75 FR 50238 through 50275 and 50414). In addition, we also defined, at § 412.101(a), the term "road miles" to mean "miles" as defined at § 412.92(c)(1), and clarified the existing regulations to indicate that a hospital must continue to qualify as a low-volume hospital in order to receive the payment adjustment in that year (that is, it is not based on a one-time qualification). Furthermore, in that same final rule, we discussed the process

for requesting and obtaining the low-volume hospital payment adjustment for FY 2011 (75 FR 50240). For the second year of the changes to the low-volume hospital adjustment provided for by the provisions of the Affordable Care Act (that is, FY 2012), consistent with the regulations at § 412.101(b)(2)(ii), we updated the discharge data source used to identify qualifying low-volume hospitals and calculate the payment adjustment (percentage increase) in the FY 2012 IPPS/LTCH PPS final rule (76 FR 51677 through 51680). Under § 412.101(b)(2)(ii), for FYs 2011 and 2012, a hospital's Medicare discharges from the most recently available MedPAR data, as determined by CMS, are used to determine if the hospital meets the discharge criteria to receive the low-volume payment adjustment in the current year. In that same final rule, we established that, for FY 2012, qualifying low-volume hospitals and their payment adjustment are determined using Medicare discharge data from the March 2011 update of the FY 2010 MedPAR file, as these data were the most recent data available at that time. In addition, we noted that eligibility for the low-volume payment adjustment for FY 2012 was also dependent upon meeting (if the hospital was qualifying for the low-volume payment adjustment for the first time in FY 2012), or continuing to meet (if the hospital qualified in FY 2011) the mileage criteria specified at § 412.101(b)(2)(ii). Furthermore, we established a procedure for a hospital to request low-volume hospital status for FY 2012 (which was consistent with the process we employed for the low-volume hospital payment adjustment for FY 2011).

3. Implementation of the Extension of the Low-Volume Hospital Payment Adjustment for FY 2013

Section 605 of the ATRA extends, for FY 2013, the temporary changes in the

low-volume hospital payment policy provided for in FYs 2011 and 2012 by the Affordable Care Act. As noted previously, prior to the enactment of section 605 of the ATRA, beginning with FY 2013, the low-volume hospital definition and payment adjustment methodology returned to the policy established under statutory requirements that were in effect prior to the amendments made by the Affordable Care Act.

Specifically, section 605 of the ATRA extends the changes made by the Affordable Care Act by amending section 1886(d)(12)(B) of the Act by striking "2013" and inserting "2014" and by amending sections 1886(d)(12)(C)(i) and (D) of the Act by striking "and 2012" and inserting ", 2012, and 2013".

Prior to the enactment of the ATRA, in the FY 2013 IPPS/LTCH PPS final rule (77 FR 53406 through 53409), we discussed the low-volume hospital payment adjustment for FY 2013 and subsequent fiscal years. Specifically, we discussed that in accordance with section 1886(d)(12) of the Act, beginning with FY 2013, the low-volume hospital definition and payment adjustment methodology reverted back to the statutory requirements that were in effect prior to the amendments made by the Affordable Care Act. Therefore, we explained, as specified under the existing regulations at § 412.101, effective for FY 2013 and subsequent years, in order to qualify as a low-volume hospital, a subsection (d) hospital must be more than 25 road miles from another subsection (d) hospital and have less than 200 discharges (that is, less than 200 total discharges, including both Medicare and non-Medicare discharges) during the fiscal year. We also established a procedure for hospitals to request low-volume hospital status for FY 2013 (which was consistent with our previously established procedures for FYs 2011 and 2012).

To implement the extension of the temporary change in the low-volume hospital payment policy for FY 2013 provided for by the ATRA, in accordance with the existing regulations at § 412.101(b)(2)(ii) and consistent with our implementation of the changes in FYs 2011 and 2012, we are updating the discharge data source used to identify qualifying low-volume hospitals and calculate the payment adjustment (percentage increase) for FY 2013. As noted previously, under § 412.101(b)(2)(ii), for FYs 2011 and FY 2012, a hospital's Medicare discharges from the most recently available MedPAR data, as determined by us, are used to determine if the hospital meets the discharge criteria to receive the low-volume payment adjustment in the current year. The applicable low-volume percentage increase provided for by the provisions of the Affordable Care Act is determined using a continuous linear sliding scale equation that results in a low-volume adjustment ranging from an additional 25 percent for hospitals with 200 or fewer Medicare discharges to a zero percent additional payment adjustment for hospitals with 1,600 or more Medicare discharges.

For FY 2013, consistent with our historical policy, qualifying low-volume hospitals and their payment adjustment will be determined using Medicare discharge data from the March 2012 update of the FY 2011 MedPAR file, as these data were the most recent data available at the time of the development of the FY 2013 payment rates and factors established in the FY 2013 IPPS/LTCH PPS final rule. Table 14 of this notice (which is available only through the Internet on the CMS Web site at http://www.cms.hhs.gov/AcuteInpatientPPS/01_overview.asp) lists the "subsection (d)" hospitals with fewer than 1,600 Medicare discharges based on the March 2012 update of the FY 2011 MedPAR files and their FY 2013 low-volume payment adjustment (if

eligible). Eligibility for the low-volume hospital payment adjustment for FY 2013 is also dependent upon meeting (in the case of a hospital that did not qualify for the low-volume hospital payment adjustment in FY 2012) or continuing to meet (in the case of a hospital that did qualify for the low-volume hospital payment adjustment in FY 2012) the mileage criterion specified at § 412.101(b)(2)(ii). We note that the list of hospitals with fewer than 1,600 Medicare discharges in Table 14 does not reflect whether or not the hospital meets the mileage criterion, and a hospital also must be located more than 15 road miles from any other IPPS hospital in order to qualify for a low-volume hospital payment adjustment in FY 2013.

In order to receive a low-volume hospital payment adjustment under § 412.101, in accordance with our previously established procedure, a hospital must notify and provide documentation to its fiscal intermediary or Medicare Administrative Contractor (MAC) that it meets the mileage criterion. The use of a Web-based mapping tool, such as MapQuest, as part of documenting that the hospital meets the mileage criterion for low-volume hospitals, is acceptable. The fiscal intermediary or MAC will determine if the information submitted by the hospital, such as the name and street address of the nearest hospitals, location on a map, and distance (in road miles, as defined in the regulations at § 412.101(a)) from the hospital requesting low-volume hospital status, is sufficient to document that it meets the mileage criterion. The fiscal intermediary or MAC may follow up with the hospital to obtain additional necessary information to determine whether or not the hospital meets the low-volume mileage criterion. In addition, the fiscal intermediary or MAC will refer to the hospital's Medicare discharge data determined by CMS to determine whether or not the hospital meets the discharge

criterion, and the amount of the FY 2013 payment adjustment, once it is determined that the mileage criterion has been met. The Medicare discharge data shown in Table 14, as well as the Medicare discharge data for all "subsection (d)" hospitals with claims in the March 2012 update of the FY 2011 MedPAR file, is also available on the CMS Web site for hospitals to view their Medicare discharges to help hospitals to decide whether or not to apply for low-volume hospital status.

Consistent with our previously established procedure, we are implementing the following procedure for a hospital to request low-volume hospital status for FY 2013. In order for the applicable low-volume percentage increase to be applied to payments for its discharges beginning on or after October 1, 2012 (that is, the beginning of FY 2013), a hospital must make its request for low-volume hospital status in writing to its fiscal intermediary or MAC by March 22, 2013. A hospital that qualified for the low-volume payment adjustment in FY 2012 may continue to receive a low-volume payment adjustment in FY 2013 without reapplying, if it continues to meet the Medicare discharge criterion, based on the March 2012 update of the FY 2011 MedPAR data (shown in Table 14) and the distance criterion; however, the hospital must verify in writing to its fiscal intermediary or MAC no later than March 22, 2013, that it continues to be more than 15 miles from any other "subsection (d)" hospital. Furthermore, for requests for low-volume hospital status for FY 2013 received after March 22, 2013, if the hospital meets the criteria to qualify as a low-volume hospital, the fiscal intermediary or MAC will apply the applicable low-volume adjustment in determining payments to the hospital's FY 2013 discharges prospectively effective within 30 days of the date of the fiscal intermediary's or MAC's low-volume status determination. (As noted previously,

this procedure is similar to the policy we established for a hospital to request low-volume hospital status for FYs 2011 and 2012 in the FY 2011 IPPS/LTCH PPS final rule (75 FR 20574 through 20575) and FY 2012 IPPS/LTCH PPS final rule (76 FR 51680), respectively.)

Program guidance on the systems implementation of these provisions, including changes to PRICER software used to make payments, will be announced in an upcoming transmittal. We intend to make conforming changes to the regulations text at 42 CFR 412.101 to reflect the changes to the qualifying criteria and the payment adjustment for low- volume hospitals according to the amendments made by section 605 of the ATRA in future rulemaking.

B. Extension of the Medicare-Dependent, Small Rural Hospital (MDH) Program

Section 606 of the ATRA provides for a 1-year extension of the Medicare-dependent, small rural hospital (MDH) program effective from October 1, 2012 to September 30, 2013. Specifically, section 606 of the ATRA of 2012 amended sections 1886(d)(5)(G)(i) and 1886(d)(5)(G)(ii)(II) of the Act by striking "October 1, 2012" and inserting "October 1, 2013". Section 606 of the ATRA of 2012 also made conforming amendments to sections 1886(b)(3)(D)(i) and 1886(b)(3)(D)(iv) of the Act. Generally, as a result of the section 606 extension, a provider that was classified as an MDH prior to the September 30, 2012 expiration of the MDH program will be reinstated as an MDH effective October 1, 2012, with no need to reapply for MDH classification.

Prior to the enactment of section 606 of the ATRA, under section 3124 of the Affordable Care Act, the MDH program authorized by section 1886(d)(5)(G) of the Act

was set to expire at the end of FY 2012. (For additional information on the MDH program and the payment methodology, we refer readers to the FY 2012 IPPS/LTCH PPS final rule (76 FR 51683 through 51684).

In the FY 2011 IPPS/LTCH PPS final rule (75 FR 50287 and 50414), we amended the regulations at § 412.108(a)(1) and (c)(2)(iii) to reflect the Affordable Care Act extension of the MDH program through FY 2012. We intend to amend the regulations at §412.108(a)(1) and (c)(2)(iii) to reflect the statutory extension of the MDH program through FY 2013 provided for by the provisions of the ATRA in future rulemaking.

Since MDH status is now extended by statute through the end of FY 2013, generally, hospitals that previously qualified for MDH status will be reinstated as an MDH retroactively to October 1, 2012. However, in the following two situations, the effective date of MDH status may not be retroactive to October 1, 2012.

1. MDHs that Classified as Sole Community Hospitals (SCHs) on or after October 1, 2012

In anticipation of the September 30, 2012 expiration of the MDH provision, we allowed MDHs that applied for reclassification as sole community hospitals (SCHs) by August 31, 2012, to have such status be effective on October 1, 2012 under the regulations at § 412.92(b)(2)(v). Hospitals that applied by the August 31, 2012 deadline and were approved for SCH classification received SCH status effective October 1, 2012. Additionally, some hospitals that had MDH status as of the September 30, 2012 expiration of the MDH program may have missed the August 31, 2012 application deadline. These hospitals applied for SCH status in the usual manner instead and were

approved for SCH status effective 30 days from the date of approval, resulting in an effective date later than October 1, 2012. These hospitals must reapply for MDH status under § 412.108(b).

2. MDHs that Requested a Cancellation of Their Rural Classification Under § 412.103(b)

One of the criteria to be classified as an MDH is that the hospital must be located in a rural area. To qualify for MDH status, some MDHs reclassified from an urban to a rural hospital designation, under the regulations at § 412.103(b). With the expiration of the MDH provision, some of these providers may have requested a cancellation of their rural classification. Therefore, in order to qualify for MDH status, these hospitals must request to be reclassified as rural under § 412.103(b) and must reapply for MDH status under § 412.108(b).

Any provider that falls within either of the two exceptions listed previously may not have its MDH status automatically reinstated effective October 1, 2012. That is, if a provider reclassified to SCH status or cancelled its rural status effective October 1, 2012, its MDH status will not be retroactive to October 1, 2012, but will instead be applied prospectively based on the date the hospital is notified that it again meets the requirements for MDH status in accordance with § 412.108(b)(4) after reapplying for MDH status. Once granted, this status will remain in effect through FY 2013, subject to the requirements at § 412.108. However, if a provider reclassified to SCH status or cancelled its rural status effective on a date later than October 1, 2012, MDH status will be reinstated effective from October 1, 2012 but will end on the date on which the provider changed its status to an SCH or cancelled its rural status. Those hospitals may

also reapply for MDH status to be effective again 30 days from the date the hospital is notified of the determination, in accordance with § 412.108(b)(4). Once granted, this status will remain in effect through FY 2013, subject to the requirements at § 412.108. Providers that fall within either of the two exceptions will have to reapply for MDH status according to the classification procedures in 42 CFR 412.108(b). Specifically, the regulations at § 412.108(b) require the following:

- The hospital submit a written request along with qualifying documentation to its contractor to be considered for MDH status.
- The contractor make its determination and notify the hospital within 90 days from the date that it receives the request for MDH classification and all required documentation.
- The determination of MDH status be effective 30 days after the date of the contractor's written notification to the hospital.

The following are examples of various scenarios that illustrate how and when MDH status will be determined for hospitals that were MDHs as of the September 30, 2012 expiration of the MDH program:

Example 1: Hospital A was classified as an MDH prior to the September 30, 2012 expiration of the MDH program. Hospital A retained its rural classification and did not reclassify as an SCH. Hospital A's MDH status will be automatically reinstated to October 1, 2012.

Example 2: Hospital B was classified as an MDH prior to the September 30, 2012 expiration of the MDH program. Per the regulations at § 412.92(b)(2)(v) and in anticipation of the expiration of the MDH program, Hospital B

applied for reclassification as an SCH by August 31, 2012, and was approved for SCH status effective on October 1, 2012. Hospital B's MDH status will not be automatically reinstated. In order to reclassify as an MDH, Hospital B must cancel its SCH status, in accordance with § 412.92(b)(4), and reapply for MDH status under the regulations at § 412.108(b).

Example 3: Hospital C was classified as an MDH prior to the September 30, 2012 expiration of the MDH program. Hospital C missed the application deadline of August 31, 2012 for reclassification as an SCH under the regulations at § 412.92(b)(2)(v) and was not eligible for its SCH status to be effective as of October 1, 2012. Hospital C's Medicare contractor approved its request for SCH status effective November 16, 2012. Hospital C's MDH status will be reinstated effective October 1, 2012 through November 15, 2012 and will subsequently be cancelled effective November 16, 2012. In order to reclassify as an MDH, Hospital C must cancel its SCH status, in accordance § 412.92(b)(4), and reapply for MDH status under the regulations at § 412.108(b).

Example 4: Hospital D was classified as an MDH prior to the September 30, 2012 expiration of the MDH program. In anticipation of the expiration of the MDH program, Hospital D requested that its rural classification be cancelled per the regulations at § 412.103(g). Hospital D's rural classification was cancelled effective October 1, 2012. Hospital D's MDH status will not be automatically reinstated. In order to reclassify as an MDH, Hospital D must request to be reclassified as rural under § 412.103(b) and must reapply for MDH status under § 412.108(b).

Example 5: Hospital E was classified as an MDH prior to the September 30, 2012

expiration of the MDH program. In anticipation of the expiration of the MDH program, Hospital E requested that its rural classification be cancelled per the regulations at § 412.103(g). Hospital E's rural classification was cancelled effective January 1, 2013. Hospital E's MDH status will be reinstated but only for the period of time during which it met the criteria for MDH status. Since Hospital E cancelled its rural status and was classified as urban effective January 1, 2013, MDH status will only be reinstated effective October 1, 2012 through December 31, 2012 and will be cancelled effective January 1, 2013. In order to reclassify as an MDH, Hospital E must request to be reclassified as rural under § 412.103(b) and must reapply for MDH status under § 412.108(b).

We note that hospitals that were MDHs as of the September 30, 2012 expiration of the MDH program that have returned to urban status will first need to apply for rural status under § 412.103(b), and hospitals that became SCHs will first need to request cancellation of SCH status under § 412.92(b)(4).

Finally, we note that hospitals continue to be bound by § 412.108(b)(4)(i) through (iii) to report a change in the circumstances under which the status was approved. Thus, if a hospital's MDH status has been extended and it no longer meets the requirements for MDH status, it is required under § 412.108(b)(4)(i) through (iii) to make such a report to its fiscal intermediary or MAC. Additionally, under the regulations at § 412.108(b)(5), Medicare contractors are required to evaluate on an ongoing basis whether or not a hospital continues to qualify for MDH status.

A provider affected by the MDH program extension will receive a notice from its Medicare contractor detailing its status in light of the MDH program extension.

Program guidance on the systems implementation of these provisions, including changes to PRICER software used to make payments, will be announced in an upcoming transmittal. We intend to make the conforming changes to the regulations text at 42 CFR 412.108 to reflect the changes made by section 606 of the ATRA in future rulemaking.

III. Collection of Information Requirements

This document does not impose information collection and recordkeeping requirements. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 35).

IV. Waiver of Proposed Rulemaking and Delay of Effective Date

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** and invite public comment prior to a rule taking effect in accordance with section 553(b) of the Administrative Procedure Act (APA) and section 1871 of the Act. In addition, in accordance with section 553(d) of the APA and section 1871(e)(1)(B)(i) of the Act, we ordinarily provide a 30-day delay to a substantive rule's effective date. For substantive rules that constitute major rules, in accordance with 5 U.S.C. 801, we ordinarily provide a 60-day delay in the effective date.

None of the processes or effective date requirements apply, however, when the rule in question is interpretive, a general statement of policy, or a rule of agency organization, procedure or practice. They also do not apply when the Congress itself has created the rules that are to be applied, leaving no discretion or gaps for an agency to fill in through rulemaking.

In addition, an agency may waive notice and comment rulemaking, as well as any delay in effective date, when the agency for good cause finds that notice and public comment on the rule as well the effective date delay are impracticable, unnecessary, or contrary to the public interest. In cases where an agency finds good cause, the agency must incorporate a statement of this finding and its reasons in the rule issued.

The policies being publicized in this notice do not constitute agency rulemaking. Rather, the Congress, in the ATRA, has already required that the agency make these changes, and we are simply notifying the public of the extension of the changes to the payment adjustment for low-volume hospitals and the MDH program for an additional year effective October 1, 2012. As this notice merely informs the public of these extensions, it is not a rule and does not require any notice and comment rulemaking. To the extent any of the policies articulated in this notice constitute interpretations of the Congress's requirements or procedures that will be used to implement the Congress's directive; they are interpretive rules, general statements of policy, and rules of agency procedure or practice, which are not subject to notice and comment rulemaking or a delayed effective date.

However, to the extent that notice and comment rulemaking or a delay in effective date or both would otherwise apply, we find good cause to waive such requirements. Specifically, we find it unnecessary to undertake notice and comment rulemaking in this instance as this notice does not propose to make any substantive changes to the policies or methodologies already in effect as a matter of law, but simply applies rate adjustments under the ATRA to these existing policies and methodologies. As the changes outlined in this notice have already taken effect, it would also be

impracticable to undertake notice and comment rulemaking. For these reasons, we also find that a waiver of any delay in effective date, if it were otherwise applicable, is necessary to comply with the requirements of the ATRA. Therefore, we find good cause to waive notice and comment procedures as well as any delay in effective date, if such procedures or delays are required at all.

V. Regulatory Impact Analysis

A. Introduction

We have examined the impacts of this notice as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96-354), section 1102(b) of the Social Security Act, section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104-4), Executive Order 13132 on Federalism (August 4, 1999), and the Congressional Review Act (5 U.S.C. 804(2)).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). Executive Order 13563 emphasizes the importance of quantifying both costs and benefits, of reducing costs, of harmonizing rules, and of promoting flexibility. A regulatory impact analysis (RIA) must be prepared for regulatory actions with economically significant effects (\$100 million or more in any 1 year). Although we do not consider this notice to constitute a substantive rule or regulatory action, the changes announced in this notice

are "economically" significant, under section 3(f)(1) of Executive Order 12866, and therefore we have prepared a RIA, that to the best of our ability, presents the costs and benefits of this notice. In accordance with Executive Order 12866, the notice has been reviewed by the Office of Management and Budget.

The RFA requires agencies to analyze options for regulatory relief of small businesses, if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small government jurisdictions. We estimate that most hospitals and most other providers and suppliers are small entities as that term is used in the RFA. The great majority of hospitals and most other health care providers and suppliers are small entities, either by being nonprofit organizations or by meeting the SBA definition of a small business (having revenues of less than \$7.5 to \$34.5 million in any 1 year). (For details on the latest standard for health care providers, we refer readers to page 33 of the Table of Small Business Size Standards at the Small Business Administration's Web site at <http://www.sba.gov/services/contractingopportunities/sizestandardsttopics/tableofsize/index.html> .) For purposes of the RFA, all hospitals and other providers and suppliers are considered to be small entities. Individuals and States are not included in the definition of a small entity. We believe that this notice will have a significant impact on small entities. Because we acknowledge that many of the affected entities are small entities, the analysis discussed in this section would fulfill any requirement for a final regulatory flexibility analysis.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number

of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. With the exception of hospitals located in certain New England counties, for purposes of section 1102(b) of the Act, we now define a small rural hospital as a hospital that is located outside of an urban area and has fewer than 100 beds.

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) (Pub. L. 104-4) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of \$100 million in 1995 dollars, updated annually for inflation. In 2012, that threshold is approximately \$136 million. This notice will not mandate any requirements for State, local, or tribal governments, nor will it affect private sector costs.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. This notice will not have a substantial effect on State and local governments.

Although this notice merely reflects the implementation of two provisions of the ATRA and does not constitute a substantive rule, we nevertheless prepared this impact analysis in the interest of ensuring that the impacts of these changes are fully understood. The following analysis, in conjunction with the remainder of this document, demonstrates that this notice is consistent with the regulatory philosophy and principles identified in Executive Order 12866 and 13563, the RFA, and section 1102(b) of the Act. The notice will positively affect payments to a substantial number of small rural hospitals and providers, as well as other classes of hospitals and providers, and the effects

on some hospitals and providers may be significant. The impact analysis, which discusses the effect on total payments to IPPS hospitals and providers, is presented in this section.

B. Statement of Need

This notice is necessary to update the IPPS final FY 2013 payment policies to reflect changes required by the implementation of two provisions of the ATRA. Section 605 of the ATRA extends the payment adjustment for low-volume hospitals through FY 2013. Section 606 of the ATRA extends the MDH program through FY 2013. As noted previously, program guidance on the systems implementation of these provisions, including changes to PRICER software used to make payments, will be announced in an upcoming transmittal.

C. Overall Impact

The FY 2013 IPPS/LTCH PPS final rule included an impact analysis for the changes to the IPPS included in that rule. This notice updates those impacts to the IPPS to reflect the changes made by sections 605 and 606 of the ATRA. Since these sections were not budget neutral, the overall estimates for hospitals have changed from our estimates that were published in the FY 2013 IPPS/LTCH PPS final rule (77 FR 53748). We estimate that the changes in the FY 2013 IPPS/LTCH PPS final rule, in conjunction with the changes included in this notice, will result in an approximate \$2.54 billion increase in total payments to IPPS hospitals relative to FY 2012. In the FY 2013 IPPS/LTCH PPS final rule (77 FR 53748), we had projected that total payments to IPPS hospitals would increase by \$2.04 billion relative to FY 2012. However, since the changes in this notice will increase payments by an estimated \$509 million relative to

what was projected in the FY 2013 IPPS/LTCH PPS final rule, these changes will result in a net increase of \$2.54 billion in total payments to IPPS hospitals relative to FY 2012, as noted previously.

D. Anticipated Effects

The impact analysis reflects the change in estimated payments to IPPS hospitals in FY 2013 due to sections 605 and 606 of the ATRA relative to estimated FY 2013 payments to IPPS hospitals published in the FY 2013 IPPS/LTCH PPS final rule (77 FR 53748). As described later in the regulatory impact analysis, FY 2013 IPPS payments to hospitals affected by sections 605 and 606 of the ATRA are projected to increase by \$509 million (relative to the FY 2013 payments estimated for these hospitals for the FY 2013 IPPS/LTCH PPS final rule). Furthermore, we project that, on the average, overall IPPS payments in FY 2013 for all hospitals will increase by 0.5 percent due to these provisions in the ATRA compared to the previous estimate of FY 2013 payments to all IPPS hospitals published in the FY 2013 IPPS/LTCH PPS final rule.

1. Effects of the Extension of the Payment Adjustment for Low-Volume Hospitals

The extension, for FY 2013, of the temporary changes to the payment adjustment for low-volume hospitals (originally provided for by the Affordable Care Act for FYs 2011 and 2012) as provided for under section 605 of the ATRA is a non-budget neutral payment provision. The provisions of the Affordable Care Act expanded the definition of low-volume hospital and modified the methodology for determining the payment adjustment for hospitals meeting that definition for FYs 2011 and 2012. Prior to the enactment of the ATRA, beginning with FY 2013, the low-volume hospital definition and payment adjustment methodology was to return to the statutory requirements that

were in effect prior to the amendments made by the Affordable Care Act. With the additional year extension provided for by the ATRA, based on FY 2011 claims data (March 2012 update of the MedPAR file), we estimate that approximately 600 hospitals will now qualify as a low-volume hospital for FY 2013. We project that these hospitals will experience an increase in payments of approximately \$326 million compared to our previous estimates of payments to these hospitals for FY 2013 published in the FY 2013 IPPS/LTCH PPS final rule.

2. Effects of the Extension of the MDH Program

The extension of the MDH program in FY 2013 as provided for under section 606 of the ATRA is a non-budget neutral payment provision. Hospitals that qualify to be MDHs receive the higher of operating IPPS payments made under the Federal standardized amount or the payments made under the Federal standardized amount plus 75 percent of the difference between the Federal standardized amount and the hospital-specific rate (a hospital-specific cost-based rate). Because this provision is not budget neutral, we estimate that the extension of this payment provision will result in a 0.2 percent increase in payments overall. Prior to the extension of the MDH program, there were 213 MDHs, of which 98 were estimated to be paid under the blended payment of the Federal standardized amount and hospital-specific rate in FY 2013. Because those 98 MDHs will now receive the blended payment (that is, the Federal standardized amount plus 75 percent of the difference between the Federal standardized amount and the hospital-specific rate) in FY 2013, we estimate that those hospitals will experience an overall increase in payments of approximately \$183 million compared to our previous

estimates of payments to these hospitals for FY 2013 published in the FY 2013 IPPS/LTCH PPS final rule.

E. Alternatives Considered

This notice provides descriptions of the statutory provisions that are addressed and identifies policies for implementing these provisions. Due to the prescriptive nature of the statutory provisions, no alternatives were considered.

F. Accounting Statement and Table

As required by OMB Circular A-4 (available at <http://www.whitehouse.gov/omb/circulars/a004/a-4.pdf>), in Table I below, we have prepared an accounting statement showing the classification of expenditures associated with the provisions of this notice as they relate to acute care hospitals. This table provides our best estimate of the change in Medicare payments to providers as a result of the changes to the IPPS presented in this notice. All expenditures are classified as transfers from the Federal government to Medicare providers. As previously discussed, relative to what was projected in the FY 2013 IPPS/LTCH PPS final rule, the changes in this notice for implementing sections 605 and 606 of the ATRA are projected to increase FY 2013 payments to IPPS hospitals by \$509 million.

TABLE I. ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES UNDER THE IPPS FROM PUBLISHED FY 2013 TO REVISED FY 2013

Category	Transfers
Annualized Monetized Transfers	\$509 million
From Whom to Whom	Federal Government to IPPS Medicare Providers
Total	\$509 million

CMS-1588-N

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare--Hospital Insurance; and Program No. 93.774, Medicare--Supplementary Medical Insurance Program)

Dated: January 30, 2013

Marilyn Tavenner,

Acting Administrator,

Centers for Medicare & Medicaid Services.

Approved: March 1, 2013

Kathleen Sebelius,

Secretary,

Department of Health and Human Services.

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