DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 412

[CMS–1599–IFC2]

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 2014

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

ACTION: Interim final rule with comment period.

SUMMARY: This interim final rule with comment period implements 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 2014 (through March 31, 2014) in accordance with sections 1105 and 1106, respectively, of the Pathway for SGR Reform Act of 2013.

DATES: *Effective date:* March 14, 2014.

Applicability dates: The provisions of this interim final rule with comment period are applicable for discharges on or after October 1, 2013, and on or before March 31, 2014.

Comment date: To be assured consideration, comments must be received at one of the addresses provided, no later than 5 p.m. on May 13, 2014.

ADDRESSES: In commenting, please refer to file code CMS–1599–IFC2. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (please choose only one of the ways listed).

1. Electronically. You may submit electronic comments on this regulation to *http://www.regulations.gov*. Follow the ''Submit a comment'' instructions.

2. By regular mail. You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1599–IFC2, P.O. Box 8013, Baltimore, MD 21244–8013.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. By express or overnight mail. You may send written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1599–IFC2, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

4. By hand or courier. Alternatively, you may deliver (by hand or courier) your written comments ONLY to the following addresses prior to the close of the comment period:

a. For delivery in Washington, DC—Centers for Medicare & Medicaid Services, Department of Health and Human Services, Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue SW., Washington, DC 20201.

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without Federal government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

b. For delivery in Baltimore, MD—Centers for Medicare & Medicaid Services, Department of Health and Human Services, 7500 Security Boulevard, Baltimore, MD 21244–01850.

If you intend to deliver your comments to the Baltimore address, call telephone number (410) 786–9994 in advance to schedule your arrival with one of our staff members.

Comments erroneously mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: Michele Hudson, (410) 786–5490. Maria Navarro, (410) 786–4553. Shevi Marciano, (410) 786–2874.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been received: *http://regulations.gov.* Follow the search instructions on that Web site to view public comments. Comments received timely will be also available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1–800–743–3951.

I. Background

On December 26, 2013, the Pathway for SGR Reform Act of 2013 (Pub. L. 113–67) was enacted. Section 1105 of the Pathway for SGR Reform Act extends changes to the payment adjustment for low-volume hospitals for an additional 6 months, through March 31, 2014, of fiscal year (FY) 2014. Section 1106 of the Pathway for SGR Reform Act extends the Medicare-dependent, small rural hospital (MDH) program for an additional 6 months, through March 31, 2014, of FY 2014.

II. Provisions of the Interim Final Rule With Comment Period

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 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. Section 605 of the American Taxpayer Relief Act of 2012 (ATRA) extended, 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. Prior to the enactment of the Pathway for SGR Reform Act, beginning with FY 2014, 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 and the ATRA. (For additional information on the expiration of the temporary changes in the low-volume hospital payment policy for FYs 2011 through 2013 provided for by the Affordable Care Act and the ATRA, refer to the FY 2014 IPPS/LTCH PPS final rule (78 FR 50610 through 50613).) 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, 2012, and 2013

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 0 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).

Section 605 of the ATRA extended the temporary changes in the low-volume hospital payment policy provided for in FYs 2011 and 2012 by the Affordable Care Act for FY 2013, that is, for discharges occurring before October 1, 2013. In a **Federal Register** notice published on March 7, 2013 (78 FR 14689 through 14694) (hereinafter referred to as the FY 2013 IPPS notice), we announced the extension of the Affordable Care Act amendments to the low-volume hospital payment adjustment requirements under section 1886(d)(12) of the Act for FY 2013 pursuant to section 605 of the ATRA. To implement the extension of the temporary change in the low-volume hospital payment adjustment policy for FY 2013 provided for by the ATRA, in the FY 2013 IPPS notice, we updated the discharge data source used to identify qualifying low-volume hospitals and calculate the payment adjustment (percentage increase). In addition, we established a procedure for a hospital to request low-volume hospital status for FY 2013 (which was consistent with the process for the low-volume hospital payment adjustment for FYs 2011 and 2012). We also noted our intent to make conforming changes to the regulations text at § 412.101 to reflect the changes to the qualifying criteria and the payment adjustment for low-volume hospitals in accordance with the amendments made by section 605 of the ATRA in future rulemaking. In the FY 2014 IPPS/LTCH PPS final rule (78 FR 50612), we adopted revisions to paragraphs (b)(2)(i), (b)(2)(ii), (c)(1), (c)(2), and (d) of § 412.101 consistent with the provisions of section 605 of the ATRA.

3. Implementation of the Extension of the Low-Volume Hospital Payment Adjustment for FY 2014 (through March 31, 2014)

Section 1105 of the Pathway for SGR Reform Act extends, for the first 6 months of FY 2014 (that is, through March 31, 2014), the temporary changes in the low-volume hospital payment policy provided for in FYs 2011 and 2012 by the Affordable Care Act and extended through FY 2013 by the ATRA. Prior to the enactment of section 1105 of the Pathway for SGR Reform Act, beginning with FY 2014, 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 as extended by the ATRA.

Section 1105 of the Pathway for SGR Reform Act extends the changes made by the Affordable Care Act and extended by the ATRA by amending sections 1886(d)(12)(B), (C)(i), and (D) of the Act. Subparagraph (B) of section 1886(d)(12) of the Act sets forth the applicable percentage increase under the original low-volume hospital payment adjustment policy established under statutory requirements that were in effect prior to the amendments made by the Affordable Care Act (that is, the time periods for which the temporary changes provided for by the Affordable Care Act, as extended by the ATRA, do not apply). Section 1105 of the Pathway for SGR Reform Act amends section 1886(d)(12)(B) by striking ''fiscal year 2014 and subsequent fiscal years'' and inserting ''the portion of fiscal year 2014 beginning on April 1, 2014, fiscal year 2015, and subsequent fiscal years.'' Section 1886(d)(12)(C)(i) of the Act, which specifies the definition of a low-volume hospital, is amended by inserting ''and the portion of fiscal year 2014 before'' after ''and 2013,'' each place it appears and by inserting ''or portion of fiscal year'' after ''during the fiscal year.'' Lastly, section 1886(d)(12)(D) of the Act, which sets forth the temporary applicable percentage increase provided for by the provisions of the Affordable Care Act and extended by the ATRA, is amended by inserting ''and the portion of fiscal year 2014 before April 1, 2014,'' after ''and 2013,'' and by inserting ''or the portion of fiscal year'' after ''in the fiscal year''.

As noted previously, section 1105 of the Pathway for SGR Reform Act amends the definition of a low-volume hospital in subparagraph (C)(i) of section 1886(d)(12) of the Act by inserting ''and the portion of fiscal year 2014 before'' after ''and 2013,'' each place it appears. This amendatory text appears to contain a technical error in that it omits ''April 1, 2014'' which is the date ''before'' which the temporary changes to the low-volume hospital definition are applicable. As amended by section 1105 of the Pathway for SGR Reform Act, section 1886(d)(12)(C)(i) of the Act reads: ''For purposes of this paragraph, the term ''low-volume hospital'' means, for a fiscal year, a subsection (d) hospital (as defined in paragraph (1)(B)) that the Secretary determines is located more than 25 road miles (or, with respect to fiscal years 2011, 2012, and 2013, and the portion of fiscal year 2014 before 15 road miles) from another subsection (d) hospital and has less than 800 discharges (or, with respect to fiscal years 2011, 2012, and 2013, and the portion of fiscal year 2014 before 1,600 discharges of individuals entitled to, or enrolled for, benefits under part A) during the fiscal year or the portion of fiscal year.'' Adding ''April 1, 2014'' after ''and the portion of fiscal year 2014 before'' would make the applicable period for the changes to section 1886(d)(12)(C) of the Act consistent with the applicable period under the other amendments to section 1886(d)(12) of the Act, which plainly state that the temporary changes to the low-volume hospital payment adjustment are applicable ''before April 1, 2014.'' Specifically, as amended by section 1105 of the Pathway for SGR Reform Act, section 1886(d)(12)(D) of the Act specifies that the ''temporary

applicable percentage increase'' (provided for by the provisions of the Affordable Care Act as extended by the ATRA) is applicable ''[f]or discharges occurring in fiscal years 2011, 2012, and 2013, and the portion of fiscal year 2014 before April 1, 2014''. Similarly, as amended by section 1105 of the Pathway for SGR Reform Act, section 1886(d)(12)(B) of the Act specifies that the applicable percentage increase under the original low-volume hospital payment adjustment policy (prior to the amendments made by the Affordable Care Act, as extended by the ATRA) applies ''[f]or discharges occurring in fiscal years 2005 through 2010 and for discharges occurring in the portion of fiscal year 2014 beginning on April 1, 2014, fiscal year 2015, and subsequent fiscal years''. Thus we believe it is clear that ''April 1, 2014'' was inadvertently omitted from the amendment to the low-volume hospital definition at section 1886(d)(12)(C)(i) of the Act under the extension provided for by section 1105 of the Pathway for SGR Reform Act and that the temporary changes to this definition are applicable to FYs 2011, 2012, and 2013, and the portion of FY 2014 before April 1, 2014, consistent with the amendments made to subparagraphs (B) and (D) of section 1886(d)(12) of the Act by section 1105 of the Pathway for SGR Reform Act. Accordingly, in this interim final rule with comment period, in implementing section 1105 of the Pathway for SGR Reform Act, we are establishing that the temporary changes to the low-volume hospital definition specified in section 1886(d)(12)(C)(i) of the Act (and implemented in § 412.101(b)(2)(ii)) are applicable to FYs 2011, 2012, and 2013, and the portion of FY 2014 before April 1, 2014 (that is, through March 31, 2014). As discussed later, we are revising the regulation text at § 412.101(b)(2)(ii) to reflect the extension of the temporary changes to the low-volume hospital definition through March 31, 2014.

To implement the extension of the temporary change in the low-volume hospital payment policy through the first half of FY 2014 (that is, for discharges occurring through March 31, 2014) provided for by the Pathway for SGR Reform Act, 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 and the extension of those changes in FY 2013, we are updating the discharge data source used to identify qualifying low-volume hospitals and calculate the payment adjustment (percentage increase) for FY 2014 discharges occurring before April 1, 2014. Under existing § 412.101(b)(2)(ii), for FYs 2011, 2012 and 2013, 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. The applicable low-volume percentage increase, as originally 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 hospital payment 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 2014 discharges occurring before April 1, 2014, consistent with our historical policy, qualifying low-volume hospitals and their payment adjustment will be determined using Medicare discharge data from the March 2013 update of the FY 2012 MedPAR file, as these data were the most recent data available at the time of the development of the FY 2014 payment rates and factors established in the FY 2014 IPPS/LTCH PPS final rule. Table 14 of this interim final rule with comment period (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 2013 update of the FY 2012 MedPAR files and their FY 2014 low-volume payment adjustment (if eligible). Eligibility for the low-volume hospital payment adjustment for the first 6 months of FY 2014 is also dependent upon meeting (in the case of a hospital that did not qualify for the low-volume hospital payment adjustment in FY 2013) or continuing to meet (in the case of a hospital that did qualify for the low-volume hospital payment adjustment in FY 2013) 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. 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 for FY 2014 discharges occurring before April 1, 2014.

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 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 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 the hospital requesting low-volume hospital status meets the mileage criterion. The MAC may follow up with the hospital to obtain additional necessary information to determine whether or not the hospital meets the low-volume hospital mileage criterion. In addition, the MAC will refer to the hospital's Medicare discharge data determined by CMS (as provided in Table 14, which is available only through the Internet on the CMS Web site at *http://www.cms.hhs.gov/AcuteInpatientPPS/01_overview.asp*) to determine whether or not the hospital meets the discharge criterion, and the amount of the payment adjustment for FY 2014 discharges occurring before April 1, 2014, 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 2013 update of the FY 2012 MedPAR file, is also available on the CMS Web site for hospitals to view the count of their Medicare discharges. The data can be used to help hospitals 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 2014 discharges occurring before April 1, 2014. In order for the applicable low-volume percentage increase to be applied to payments for its discharges beginning on or after October 1, 2013 (that is, the beginning of FY 2014), a hospital must make its request for low-volume hospital status in writing and this request must be received by its MAC no later than March 31, 2014. A hospital that qualified for the low-volume payment adjustment in FY 2013 may continue to receive a low-volume payment adjustment for FY 2014 discharges occurring before April 1, 2014 without reapplying if it continues

to meet the Medicare discharge criterion, based on the March 2013 update of the FY 2012 MedPAR data (shown in Table 14), and the distance criterion; however, the hospital must send written verification that is received by its MAC no later than March 31, 2014, that it continues to be more than 15 miles from any other ''subsection (d)'' hospital. This procedure is similar to the policy we established in the FY 2013 IPPS notice (78 FR 14689) implementing the extension of the temporary changes to the low-volume hospital payment adjustment for FY 2013 provided by section 605 of the ATRA, as well as the procedure for a hospital to request low-volume hospital status in the FY 2011 IPPS/LTCH final rule (see 75 FR 50274 through 50275) and FY 2012 IPPS/LTCH final rule (see 76 FR 51680) under the provisions of the Affordable Care Act.

Requests for low-volume hospital status for FY 2014 discharges occurring before April 1, 2014 that are received by the MAC after March 31, 2014 will be processed by the MAC, however, the hospital will not be eligible to have the low-volume hospital payment adjustment at § 412.101(c)(2) applied to such discharges. In general, this approach is consistent with our procedure for application of the extension of the changes to the low-volume payment adjustment for FY 2013 provided for by the ATRA to payments for discharges beginning on or after October 1, 2012. The MAC also will not apply the low-volume hospital payment adjustment at § 412.101(c)(2) prospectively in determining payments for the hospital's FY 2014 discharges, because, beginning on April 1, 2014, the 6-month extension of the temporary changes to the low-volume hospital payment adjustment policy provided for by the Pathway for SGR Reform Act will have expired and the low-volume hospital definition and payment methodology will revert back to the statutory requirements that were in effect prior to the amendments made by the Affordable Care Act. If the hospital would have otherwise met the criteria to qualify as a low-volume hospital under the temporary changes to the low-volume hospital policy, the MAC will notify the hospital that, although the hospital meets the low-volume hospital criteria set forth at § 412.101(b)(2)(ii) and would have had low-volume hospital status within 30 days from the date of the determination, the hospital does not meet the criteria for low-volume hospital status applicable for discharges occurring on or after April 1, 2014 at § 412.101(b)(2)(i).

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. In this interim final rule with comment, we are amending the regulations text at 42 CFR 412.101 to make conforming changes to the qualifying criteria and the payment adjustment for low-volume hospitals according to the amendments made by section 1105 of the Pathway for SGR Reform Act discussed previously.

In accordance with section 1886(d)(12) of the Act, beginning on April 1, 2014, the low-volume hospital definition and payment adjustment methodology will revert back to the statutory requirements that were in effect prior to the amendments made by the Affordable Care Act (as amended by the ATRA and the Pathway for SGR Reform Act). Specifically, for FY 2014 discharges occurring on or after April 1, 2014 and in 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. (For additional information on the expiration of the temporary changes to the low-volume hospital payment adjustment, refer to section V.C.3. of the preamble of the FY 2014 IPPS/LTCH PPS final rule (78 FR 50612).)

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

Section 1106 of the Pathway for SGR Reform Act of 2013 provides for a 6-month extension of the Medicare-dependent, small rural hospital (MDH) program, effective from October 1, 2013 to March 31, 2014. Specifically, section 1106 of the Pathway for SGR Reform Act amended sections 1886(d)(5)(G)(i) and 1886(d)(5)(G)(ii)(II) of the Act by striking ''October 1, 2013'' and inserting ''April 1, 2014''. Section 1106 of the Pathway for SGR Reform Act 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 this extension, a provider that was classified as an MDH as of the September 30, 2013 expiration of the MDH program, will be reinstated as an MDH effective October 1, 2013 through March 31, 2014, subject to the requirements of the regulations at § 412.108, with no need to reapply for MDH classification. (For additional information on the MDH program and the payment methodology, refer to the FY 2012 IPPS/LTCH PPS final rule (76 FR 51683 through 51684).)

Prior to the enactment 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 to expire at the end of FY 2012. Section 606 of the ATRA extended the MDH program through FY 2013. In the FY 2013 IPPS notice (78 FR 14689), we announced the extension of the MDH program through FY 2013 as provided by section 606 of the ATRA. We made the conforming regulatory changes in the FY 2014 IPPS/LTCH final rule (78 FR 50648 and 50966), amending the regulations at § 412.108(a)(1) and (c)(2)(iii) to reflect the statutory extension of the MDH program through FY 2013.

In this FY 2014 IPPS interim final rule with comment period, we are amending the regulations at § 412.108(a)(1) and (c)(2)(iii) to reflect the statutory extension of the MDH program through March 31, 2014, as provided for by section 1106 of the Pathway for SGR Reform Act. Since MDH status is now extended by statute through March 31, 2014, generally, hospitals that previously qualified for MDH status will be reinstated as an MDH retroactively to October 1, 2013. However, in the following two situations, the effective date of MDH status may not be retroactive to October 1, 2013.

1. MDHs That Classified as Sole Community Hospitals (SCHs) On or After October 1, 2013

In anticipation of the September 30, 2013 expiration of the MDH provision, and because a hospital cannot be both an SCH and an MDH (see section 1886(d)(5)(G)(iv)(III) of the Act and § 412.108(a)(1)(ii)), we allowed MDHs that applied for reclassification as sole community hospitals (SCHs) by August 31, 2013, to have such status be effective on October 1, 2013 under the regulations at § 412.92(b)(2)(v). MDHs that applied by the August 31, 2013 deadline and were approved for SCH classification received SCH status effective October 1, 2013. Hospitals that applied for SCH status after the August 31, 2013 SCH application deadline would have been subject to the usual effective date for SCH classification, that is, 30 days after the date of CMS' written notification of approval, resulting in an effective date of SCH status later than October 1, 2013. (This policy was noted in the FY 2014 IPPS/LTCH PPS final rule (78 FR 50648).)

In order to be reclassified as an MDH, these hospitals must first cancel their SCH status according to § 412.92(b)(4), because a hospital cannot be both an

SCH and an MDH, and then reapply and be approved for MDH status under § 412.108(b). However, we note that because the partial year extension of the MDH program pursuant to section 1106 of the Pathway to SGR Reform Act expires on March 31, 2014, there may not be sufficient time for hospitals that have reclassified as SCHs in anticipation of the expiration of the MDH program to cancel their SCH status in accordance with § 412.92(b)(4) and then reapply and be approved for MDH status under § 412.108(b) with an effective date prior to the March 31, 2014 expiration of the MDH program. Under § 412.92(b)(4), a hospital's cancellation of its SCH classification becomes effective no later than 30 days after the date the hospital submits its request. Under § 412.108(b)(3), the Medicare contractor will make a determination regarding whether a hospital meets the criteria for MDH status and notify the hospital within 90 days from the date that it receives the hospital's request and all of the required documentation. Under § 412.108(b)(4), a determination of MDH status made by the Medicare contractor is effective 30 days after the date the fiscal intermediary provides written notification to the hospital.

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 September 30, 2013 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 again request to be reclassified as rural under § 412.103(b) and must also reapply for MDH status under § 412.108(b).

We note that because the partial year extension of the MDH program pursuant to section 1106 of the Pathway to SGR Reform Act expires on March 31, 2014, there may not be sufficient time for hospitals that have canceled their rural reclassification in anticipation of the expiration of the MDH program to request to be reclassified as rural under § 412.103(b) and then reapply and be approved for MDH status under § 412.108(b) with an effective date before the March 31, 2014 expiration of the MDH program. As noted previously, under § 412.108(b)(3), the Medicare contractor will make a determination regarding whether a hospital meets the criteria for MDH status and notify the hospital within 90 days from the date that it receives the hospital's request and all of the required documentation. Under § 412.108(b)(4), a determination of MDH status made by the Medicare contractor is effective 30 days after the date the fiscal intermediary provides written notification to the hospital.

Any provider that falls within either of the two exceptions listed previously may not have its MDH status automatically reinstated effective October 1, 2013. That is, if a provider reclassified to SCH status or cancelled its rural status effective October 1, 2013, its MDH status will not be retroactive to October 1, 2013, but will instead be applied prospectively, if time permits, 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 the hospital reapplies for MDH status. Once granted, this MDH status will remain in effect through March 31, 2014, 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, 2013, MDH status will be reinstated effective from October 1, 2013 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 March 31, 2014 subject to the requirements at § 412.108. Providers that fall within either of the two exceptions, in order to reclassify as an MDH, 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.

For any MDH status requests received after March 31, 2014 (or for which the Medicare contractor's determination is made within 30 days of March 31, 2014, such that the effective date of MDH status would be after March 31, 2014), the Medicare contractor will process the request and send a letter to the hospital indicating that, although the hospital meets the MDH classification criteria set forth at § 412.108(a) and would have had a MDH status effective date of 30 days from the date of that letter, the MDH program has expired by that date under current law. That is, because section 1106 of the Pathway for SGR Reform Act extends the MDH program through March 31, 2014 only, MDH status cannot be applied for requests received after March 31, 2014 (or for which the Medicare contractor's determination is made within 30 days of March 31, 2014, such that the effective date of MDH status would be after March 31, 2014). The following are examples of various scenarios that illustrate how and when MDH status under section 1106 of the Pathway to SGR Reform Act will be determined for hospitals that were MDHs as of the September 30, 2013 expiration of the MDH program, subject to the timing considerations we have described previously:

Example 1: Hospital A was classified as an MDH as of the September 30, 2013 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 retroactively to October 1, 2013.

Example 2: Hospital B was classified as an MDH as of the September 30, 2013 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, 2013, and was approved for SCH status effective on October 1, 2013. Hospital B's MDH status will not be automatically reinstated. In order to reclassify as an MDH, Hospital B must first 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 as of the September 30, 2013 expiration of the MDH program. Hospital C missed the application deadline of August 31, 2013 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, 2013. The MAC approved Hospital C's request for SCH status effective November 16, 2013. Hospital C's MDH status will be reinstated effective October 1, 2013 through November 15, 2013 and MDH status will be cancelled effective November 16, 2013. 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 as of the September 30, 2013 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, 2013. Hospital D's MDH status will not be automatically reinstated. In order to reclassify as an MDH, Hospital D must first 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 as of the September 30, 2013 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, 2014. 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, 2014, MDH status will only be reinstated effective October 1, 2013 through December 31, 2013, and will be cancelled effective January 1, 2014. In order to reclassify as an MDH, Hospital E must first request to be reclassified as rural under § 412.103(b) and must reapply for MDH status under § 412.108(b).

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 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.

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. A provider affected by the MDH program extension will receive a notice from its MAC detailing its status in light of the MDH program extension. In this interim final rule with comment period, we are making conforming changes to the regulations text at § 412.108(a)(1) and (c)(2)(iii) to reflect the changes made by section 1106 of the Pathway to SGR Reform Act of 2013.

We also note that, in the FY 2014 IPPS/LTCH PPS final rule (78 FR 50620 through 50647), we implemented the changes to the payment adjustment methodology for Medicare disproportionate share hospitals (DSHs) required under section 3133 of the Affordable Care Act, which includes the new ''uncompensated care payment'' that began in FY 2014. In that same final rule (78 FR 50645), we adopted a policy of including an interim uncompensated care payment in the payment for each hospital discharge (that is, distributing interim uncompensated care payments on a per-discharge basis). At cost report settlement, we reconcile the total amounts paid on a per-discharge basis during the Federal fiscal year with the amount of the uncompensated care payment calculated for each hospital.

SCHs are paid based on their hospital-specific rate from certain specified base years or the Federal rate, whichever yields the greatest aggregate payment for the hospital's cost reporting period. In the FY 2014 IPPS/LTCH PPS final rule (78 FR 50644), we established a policy of including the uncompensated care payment amount as part of the Federal rate payment in the comparison of payments under the hospital-specific rate and the Federal rate for SCHs. Uncompensated care payments to MDHs were not explicitly addressed in the FY 2014 IPPS/LTCH PPS final rule because, prior to the enactment of the Pathway for SGR Reform Act, the MDH program was to expire at the end of FY 2013.

Section 1886(d)(5)(G) of the Act provides that, for discharges occurring on or after October 1, 2006, MDHs are paid based on the Federal rate or, if higher, the Federal rate plus 75 percent of the amount by which the Federal rate is exceeded by the updated hospital-specific rate from certain specified base years (see 76 FR 51684). The ''Federal rate'' used in the MDH payment methodology is the same ''Federal rate'' that is used in the SCH payment methodology. Accordingly, consistent with the policy established for SCHs in the FY 2014 IPPS/LTCH PPS final rule, in determining MDH payments for discharges occurring on or after October 1, 2013 and before April 1, 2014, a pro rata share of the uncompensated care payment amount for that period will be included as part of the Federal rate payment in the comparison of payments under the hospital-specific rate and the Federal rate. That is, in making this comparison at cost report settlement, we will include the pro rata share of the uncompensated care payment amount that reflects the period of time the hospital was paid under the MDH program for its discharges occurring on or after October 1, 2013 and before April 1, 2014. Consistent with the policy established for hospitals with Medicare cost reporting periods that span more than one Federal fiscal year in the interim final rule that appeared in the October 3, 2013 **Federal Register** titled ''FY 2014 IPPS Changes to Certain Cost Reporting Procedures Related to Disproportionate Share Hospital Uncompensated Care Payments'' (78 FR 61191), this pro rata share will be determined based on the proportion of the applicable Federal fiscal year that is included in that cost reporting period (78 FR 61192 through 61194).

Section 1106 of the Pathway for SGR Reform Act provides for an extension of the MDH program through March 31, 2014, only. Therefore, beginning April 1, 2014, all hospitals that previously qualified for MDH status will no longer have MDH status. At that time, the general policy and payment methodology will be the same as discussed in the FY 2014 IPPS/LTCH PPS final rule (78 FR 50648).

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. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

V. 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 statute establishes rules 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 Pathway for SGR Reform Act requires the agency make the changes to the payment adjustment for low-volume hospitals and the MDH program set forth in this interim final rule with comment period for an additional 6 months, effective October 1, 2013 through March 31, 2014. We are conforming our regulations to specific statutory requirements contained in sections 1105 and 1106 of the Pathway to SGR Reform Act or that directly result from those statutory requirements and informing the public of the procedures and practices the agency will follow to ensure compliance with those statutory provisions. To the extent that notice and comment rulemaking or a delay in effective date or both would otherwise apply, we believe that there is good cause to waive such requirements and to implement the requirements of section 1105 and 1106 of the Pathway to SGR Reform Act through an interim final rule with comment period. Specifically, we find it unnecessary to undertake notice and comment rulemaking in this instance because this interim final rule with comment period sets forth the requirements for the extension of the temporary changes to the payment adjustment for low-volume hospitals and the MDH program as prescribed by the Pathway to SGR Reform Act. As the changes outlined in this interim final rule with comment period have already taken effect, it would also be impracticable to undertake notice and comment rulemaking. For the reasons outlined, we find good cause to waive the notice of proposed rulemaking for the requirements for the extension of the temporary changes to the payment adjustment for low-volume hospitals and the MDH program as prescribed by the Pathway to SGR Reform Act and issue these provisions on an interim final basis. Even though we are waiving notice of proposed rulemaking requirements and are issuing these provisions on an interim basis, we are providing a 60-day public comment period.

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 Pathway for SGR Reform Act of 2013. Therefore, we find good cause to waive notice and comment procedures as well as any delay in effective date.

VI. Regulatory Impact Analysis

A. Introduction

We have examined the impacts of this rule 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). The changes announced in this interim final rule with comment period 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 interim final rule with comment period. In accordance with Executive Order 12866, this interim final rule with comment period 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 Small Business Administration 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/sizestandardstopics/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 interim final rule with comment period 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 2014, that threshold is approximately $141 million. This interim final rule with comment period 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 interim final rule with comment period will not have a substantial effect on State and local governments.

Although this interim final rule with comment period merely reflects the implementation of two provisions of the Pathway for SGR Reform Act of 2013, 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 interim final rule with comment period 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 provisions of this interim final rule with comment period 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 interim final rule with comment period is necessary to update the FY 2014 IPPS final payment policies to reflect changes required by the implementation of two provisions of the Pathway for SGR Reform Act. Section 1105 of the Pathway for SGR Reform Act extends the payment adjustment for low-volume hospitals through March 31, 2014. Section 1106 of the Pathway for SGR Reform Act extends the MDH program through March 31, 2014. 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 2014 IPPS/LTCH PPS final rule included an impact analysis for the changes to the IPPS included in that rule. This interim final rule with comment period updates those impacts to the IPPS to reflect the changes made by sections 1105 and 1106 of the Pathway for SGR Reform Act. Since these sections were not budget neutral, the overall estimates for hospitals have changed from our estimates that were published in the FY 2014 IPPS/LTCH PPS final rule (78 FR 51037). We estimate that the changes in the FY 2014 IPPS/LTCH PPS final rule, in conjunction with the changes included in this interim final rule with comment period, will result in an approximate $1.44 billion increase in total payments to IPPS hospitals relative to FY 2013 rather than the $1.2 billion increase we projected in the FY 2014 IPPS/LTCH PPS final rule (78 FR 51037).

D. Anticipated Effects

The impact analysis reflects the change in estimated payments to IPPS hospitals in FY 2014 as a result of the implementation of sections 1105 and 1106 of the Pathway for SGR Reform Act relative to estimated FY 2014 payments to IPPS hospitals that were published in the FY 2014 IPPS/LTCH PPS final rule (78 FR 51037). As described later in this regulatory impact analysis, FY 2014 IPPS payments to hospitals affected by sections 1105 and 1106 of the Pathway for SGR Reform Act are projected to increase by $227 million (relative to the FY 2014 payments estimated for these hospitals for the FY 2014 IPPS/LTCH PPS final rule). Therefore, we project that, on the average, overall IPPS payments in FY 2014 for all hospitals will increase by approximately an additional 0.24 percent as a result of the estimated $227 million increase in payments due to the provisions in the Pathway for SGR Reform Act compared to the previous estimate of FY 2014 payments to all IPPS hospitals published in the FY 2014 IPPS/LTCH PPS final rule.

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

The 6-month extension, through March 31, 2014, 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 and extended through FY 2013 under section 605 of the ATRA) as provided for under section 1105 of the Pathway for SGR Reform Act 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, and the provisions of the ATRA provided for an additional year extension, through FY 2013.

Prior to the enactment of the Pathway for SGR Reform Act, beginning October 1, 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 and the ATRA. With the additional 6-month extension, through March 31, 2014, provided for by the Pathway for SGR Reform Act, based on FY 2012 claims data (March 2013 update of the MedPAR file), we estimate that approximately 600 hospitals will now qualify as a low-volume hospital through March 31, 2014. We project that these hospitals will experience an increase in payments of approximately $161 million as compared to our previous estimates of payments to these hospitals for FY 2014 published in the FY 2014 IPPS/LTCH PPS final rule.

2. Effects of the Extension of the MDH Program

The extension of the MDH program through March 31, 2014 as provided for under section 1106 of the Pathway for SGR Reform Act is a non-budget neutral payment provision. Hospitals that qualify as a 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 0.1 percent increase in payments overall. Prior to the extension of the MDH program, there were 198 MDHs, of which 118 were estimated to be paid under the blended payment of the Federal standardized amount and hospital-specific rate in FY 2013 (78 FR 51019). Because those 118 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) for the first half of FY 2014 (until April 1, 2014), we estimate that those hospitals will experience an overall increase in payments of approximately $66 million as compared to our previous estimates of payments to these hospitals for FY 2014 published in the FY 2014 IPPS/LTCH PPS final rule.

E. Alternatives Considered

This interim final rule with comment period 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, we have prepared an accounting statement showing the classification of expenditures associated with the provisions of this interim final rule with comment period 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 interim final rule with comment period. All expenditures are classified as transfers from the Federal government to Medicare providers. As previously discussed, relative to what was projected in the FY 2014 IPPS/LTCH PPS final rule, the changes in this interim final rule with comment period to implement sections 1105 and 1106 of the Pathway for SGR Reform Act of 2013 are projected to increase FY 2014 payments to IPPS hospitals by approximately $227 million.

TABLE I—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES UNDER THE IPPS FROM PUBLISHED FY 2014 TO REVISED FY 2014

Category	Transfers
Annualized Monetized Transfers	$227 million.
From Whom to Whom	Federal Government to IPPS Medicare Providers.
Total	$227 million.

List of Subjects in 42 CFR Part 412

Administrative practice and procedure, Health facilities, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

For the reasons stated in the preamble of this interim final rule with comment period, the Centers for Medicare & Medicaid Services is amending 42 CFR Chapter IV as follows:

PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

■ 1. The authority citation for Part 412 continues to read as follows:

Authority: Sections 1102, 1862, and 1871 of the Social Security Act (42 U.S.C. 1302, 1395y, and 1395hh).

§ 412.101 [Amended]

■ 2. Section 412.101 is amended by—

■ A. In paragraph (b)(2)(i), removing the phrase ''FY 2014 and subsequent fiscal years,'' and adding in its place the phrase ''the portion of FY 2014 beginning on April 1, 2014, FY 2015, and subsequent fiscal years,''.

■ B. In paragraph (b)(2)(ii), removing the phrase ''For FY 2011, FY 2012, and FY 2013,'' and adding in its place the phrase ''For FY 2011, FY 2012, FY 2013, and the portion of FY 2014 before April 1, 2014,''.

■ C. In paragraph (c)(1), removing the phrase ''FY 2014 and subsequent fiscal years,'' and adding in its place the phrase ''the portion of FY 2014 beginning on April 1, 2014 and subsequent fiscal years,''.

■ D. In paragraph (c)(2) introductory text, removing the phrase ''For FY 2011, FY 2012, and FY 2013,'' and adding in its place the phrase ''For FY 2011, FY 2012, FY 2013, and the portion of FY 2014 before April 1, 2014,''.

■ E. In paragraph (d), removing the phrase ''FY 2014 and subsequent fiscal years,'' and adding in its place the phrase ''the portion of FY 2014 beginning on April 1, 2014 and subsequent fiscal years,''.

§ 412.108 [Amended]

■ 3. Section 412.108 is amended by—

■ A. In paragraph (a)(1) introductory text, removing the phrase ''before October 1, 2013'' and adding in its place the phrase ''before April 1, 2014''.

■ B. In paragraph (c)(2)(iii) introductory text, removing the phrase ''before October 1, 2013'' and adding in its place the phrase ''before April 1, 2014''.

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

Dated: February 26, 2014.

Marilyn Tavenner,

Administrator, Centers for Medicare & Medicaid Services.

Approved: March 6, 2014.

Kathleen Sebelius,

Secretary, Department of Health and Human Services.

[FR Doc. 2014–05922 Filed 3–14–14; 11:15 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 412, 413, 414, 419, 424, 482, 485, and 489

[CMS–1599–& 1455–CN5]

RINs 0938–AR53 and 0938–AR73

Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2014 Rates; Quality Reporting Requirements for Specific Providers; Hospital Conditions of Participation; Payment Policies Related to Patient Status; Corrections

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

ACTION: Final rules; correction.

SUMMARY: This document corrects technical errors in the final rules that appeared in the August 19, 2013 **Federal Register** titled ''Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2014 Rates; Quality Reporting Requirements for Specific Providers; Hospital Conditions of Participation; Payment Policies Related to Patient Status.''

DATES: This correcting document is effective on March 18, 2014.

FOR FURTHER INFORMATION CONTACT: Cindy Tourison (410) 786–1093.

SUPPLEMENTARY INFORMATION: