



[Billing Code: 4120-01-P]

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS-1677-N]

RIN 0938-ZB47

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 2018

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

ACTION: Extension of a payment adjustment and a program.

SUMMARY: This document 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 2018 in accordance with sections 50204 and 50205, respectively, of the Bipartisan Budget Act of 2018.

DATES: Effective Date: The extensions are effective [Insert date of filing for public inspection].

Applicability Date: The provisions described in this document are applicable for discharges on or after October 1, 2017 and on or before September 30, 2018.

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SUPPLEMENTARY INFORMATION:

I. Background

On February 9, 2018 the Bipartisan Budget Act of 2018 (Pub. L. 115–123) was enacted. Section 50204 of the Bipartisan Budget Act of 2018 extends certain temporary changes to the payment adjustment for low-volume hospitals for an additional year, through fiscal year (FY) 2018. Section 50205 of the Bipartisan Budget Act of 2018 extends the Medicare-dependent hospital (MDH) program through FY 2022 and revises the definition of an MDH.

II. Provisions of the Document

A. Extension of the Payment Adjustment for Low-Volume Hospitals

1. Background

Section 1886(d)(12) of the Act provides for an additional payment to each qualifying low-volume hospital under the IPPS beginning in FY 2005. The additional payment adjustment to a low-volume hospital provided for under section 1886(d)(12) of the Act is “[i]n addition to any payment calculated under this section.” Therefore, the additional payment adjustment is based on the per discharge amount paid to the qualifying hospital under section 1886 of the Act. In other words, the low-volume hospital payment adjustment is based on total per discharge payments made under section 1886 of the Act, including capital, DSH, IME, and outlier payments. For SCHs and MDHs, the low-volume hospital payment adjustment is based in part on either the Federal rate or the hospital-specific rate, whichever results in a greater operating IPPS payment.

The Affordable Care Act amended section 1886(d)(12) of the Act by modifying the definition of a low-volume hospital and the methodology for calculating the payment adjustment for low-volume hospitals, effective only for discharges occurring during FYs 2011 and 2012 while subsequent legislation extended these modifications through FY 2017. (We refer readers to the FY 2017 IPPS/LTCH PPS final rule (81 FR 56941 through 59943) for a detailed summary of the applicable legislation.)

Prior to the enactment of the Bipartisan Budget Act of 2018 (Pub. L. 115–123) on February 9, 2018, beginning with FY 2018, the low-volume hospital qualifying criteria and payment adjustment methodology returned to the statutory requirements that were in effect prior to FY 2011. However, section 50204 of the Bipartisan Budget Act of 2018 extended for an additional year, through FY 2018, the temporary changes in the low-volume hospital definition and methodology for determining the payment adjustment originally made by the Affordable Care Act for FYs 2011 and 2012. (We note that section 50204 of the Bipartisan Budget Act of 2018 also further modified the definition of a low-volume hospital and the methodology for calculating the payment adjustment for low volume hospitals for FYs 2019 through 2022, as addressed in separate rulemaking.) For additional information on the expiration of these provisions, we refer readers to the FY 2018 IPPS/LTCH PPS final rule (82 FR 38184 through 38188). 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 through 2017

As discussed previously, for FYs 2011 through 2017, the Affordable Care Act and subsequent legislation expanded the definition of low-volume hospital and modified the methodology for determining the payment adjustment for hospitals meeting that

definition. Specifically, those provisions amended the qualifying criteria for low-volume hospitals under section 1886(d)(12)(C)(i) of the Act to specify that, for FYs 2011 through 2017, a subsection (d) 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, these provisions amended section 1886(d)(12)(D) of the Act, to provide that for FYs 2011 through 2017, 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 note that under § 412.101(b)(2)(ii), for FYs 2011 through 2017, 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 criterion to receive the low-volume hospital payment adjustment in the applicable year.)

3. Implementation of the Extension of the Temporary Changes to the Low-Volume Hospital Definition and Payment Adjustment Methodology for FY 2018

Section 50204 of the Bipartisan Budget Act of 2018 extended, for FY 2018, the temporary changes in the low-volume hospital payment policy originally provided for in the Affordable Care Act. As noted previously, prior to the enactment of section 50204 of the Bipartisan Budget Act of 2018, beginning with FY 2018, 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 50204 of the Bipartisan Budget Act of 2018 amended section 1886(d)(12)(C) of the Act to extend the changes to the qualification criteria to FY 2018 (as reflected by new clause (i)(II)) and amended section 1886(d)(12)(D) of the Act to extend the applicable percentage increase to FY 2018 (as reflected by new clause (i)), and made other conforming changes to section 1886(d)(12)(C) and (D) of the Act.

Prior to the enactment of the Bipartisan Budget Act of 2018, in the FY 2018 IPPS/LTCH PPS final rule (82 FR 38184 through 38188), we discussed the low-volume hospital payment adjustment for FY 2018 and subsequent fiscal years. Specifically, we discussed that in accordance with section 1886(d)(12) of the Act, beginning with FY 2018, 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 2018 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 discussed the procedure for hospitals to request low-volume hospital status for FY 2018 (which was consistent with our previously established procedures for FYs 2011 through 2017).

To implement the extension of the temporary changes in the low-volume hospital payment policy for FY 2018 provided for by the Bipartisan Budget Act of 2018, in accordance with the existing regulations at §412.101(b)(2)(ii) and consistent with our

implementation of the changes in FYs 2011 through 2017, we are updating the discharge data source used to identify qualifying low-volume hospitals and calculate the payment adjustment (percentage increase) for FY 2018. As noted previously, under §412.101(b)(2)(ii), for FYs 2011 through 2017, 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 criterion 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 and subsequent legislation 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 2018, consistent with our historical policy, qualifying low-volume hospitals and their payment adjustment will be determined using Medicare discharge data from the March 2017 update of the FY 2016 MedPAR file, as these data were the most recent data available at the time of the development of the FY 2018 payment rates and factors established in the FY 2018 IPPS/LTCH PPS final rule. Table 1 of this document (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 2017 update of the FY 2016 MedPAR files and their FY 2018 low-volume payment adjustment (if eligible). Eligibility for the low-volume hospital payment adjustment for FY 2018 is also dependent upon meeting (in the case of a hospital that did not qualify for the low-volume

hospital payment adjustment in FY 2017) or continuing to meet (in the case of a hospital that did qualify for the low-volume hospital payment adjustment in FY 2017) 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 1 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 2018.

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 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 it 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 mileage criterion. In addition, the 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 2018 payment adjustment, once it is determined that the mileage criterion has been met. The Medicare discharge data shown in Table 1, as well as the Medicare discharge data for all "subsection (d)" hospitals with claims in the March 2017 update of the

FY 2016 MedPAR file, is also available on the CMS Website for hospitals to view their Medicare discharges to help hospitals to decide whether or not to apply for low-volume hospital status for FY 2018.

Consistent with our previously established procedure, we are applying the following procedure for a hospital to request low-volume hospital status for FY 2018. In order for the applicable low-volume percentage increase to be applied to payments for its discharges beginning on or after October 1, 2017 (that is, the beginning of FY 2018), a hospital must send a written request for low-volume hospital status that is received by its MAC no later than **[insert 30 days from the date of publication in the Federal Register]**. A hospital that qualified for the low-volume payment adjustment in FY 2017 may continue to receive a low-volume payment adjustment in FY 2018 without reapplying, if it continues to meet the Medicare discharge criterion, based on the March 2017 update of the FY 2016 MedPAR data (shown in Table 1), and the distance criterion; however, the hospital must send written verification that is received by its MAC no later than **[insert 30 days from the date of publication in the Federal Register]**, that it continues to be more than 15 miles from any other "subsection (d)" hospital. In this case, the written verification could be a brief letter to the MAC stating that the hospital continues to meet the low-volume hospital distance criterion as documented in a prior low-volume hospital status request. For hospitals that newly qualify for the low-volume adjustment (that is, hospitals that did not receive the low-volume adjustment in FY 2017), the written request for low-volume hospital status should include the documentation described above. Furthermore, for written requests or written verification for low-volume hospital status for FY 2018 received after **[insert 30 days from the date of publication in the Federal**

Register], if the hospital meets the criteria to qualify as a low-volume hospital, the MAC will apply the applicable low-volume hospital adjustment in determining payments for the hospital's FY 2018 discharges prospectively effective within 30 days of the date of the MAC's low-volume hospital status determination. (As noted previously, this procedure is similar to our previously established procedure for requesting low volume hospital status, as well as the procedures we used to implement prior extensions of the Affordable Care Act amendments to the low-volume hospital payment policy.)

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 50204 of the Bipartisan Budget Act of 2018, including the implementation of the provisions specifying the low-volume hospital discharge criterion and payment adjustment methodology for FYs 2019 through 2022, in future rulemaking.

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

Section 1886(d)(5)(G) of the Act provides special payment protections, under the IPPS, to a MDH. (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).) Prior to the Bipartisan Budget Act of 2018, the MDH program had been extended by the Affordable Care Act and subsequent legislation through FY 2017 (that is, for discharges occurring before October 1, 2017).

Section 50205 of the Bipartisan Budget Act of 2018 provides for an extension of

the MDH program for discharges occurring on or after October 1, 2017, through FY 2022 (that is, for discharges occurring on or before September 30, 2022). Specifically, section 50205 of the Bipartisan Budget Act of 2018 amended sections 1886(d)(5)(G)(i) and 1886(d)(5)(G)(ii)(II) of the Act by striking "October 1, 2017" and inserting "October 1, 2022". It also amended the definition of an MDH at section 1886(d)(5)(G)(iv) by striking subclause (I) and inserting a new subclause that reads, “(I) that is located in— (aa) a rural area; or (bb) a State with no rural area (as defined in paragraph (2)(D)) and satisfies any of the criteria in subclause (I), (II), or (III) of paragraph (8)(E)(ii).” It also amended section 1886(d)(5)(G)(iv) by inserting a provision after subclause (IV) to specify that new subclause (I)(bb) applies for purposes of MDH payment under section 1886(d)(5)(G)(ii) of the Act (that is, 75 percent of the amount by which the Federal rate is exceeded by the updated hospital-specific rate from certain specified base years) only for discharges of a hospital occurring on or after the effective date of a determination of MDH status made with respect to the hospital after the date of the enactment of this provision. Furthermore, this same new provision also states “For purposes of applying subclause (II) of paragraph (8)(E)(ii) under subclause (I)(bb), such subclause (II) shall be applied by inserting ‘as of January 1, 2018,’ after ‘such State’ each place it appears.” That is, this provision specifies that for a hospital in a State with no rural area, the criteria in paragraph (8)(E)(ii)(II) must have been satisfied as of January 1, 2018. Section 50205 of the Bipartisan Budget Act also made conforming amendments to sections 1886(b)(3)(D) of the Act (in the language preceding clause (i) and 1886(b)(3)(D)(iv) of the Act).

a. Extension of the MDH Program

Generally, as a result of the section 50205 of the Bipartisan Budget Act of 2018 extension, a provider that was classified as an MDH prior to the September 30, 2017 expiration of the MDH program will be reinstated as an MDH effective October 1, 2017, with no need to reapply for MDH classification.

Prior to the enactment of section 50205 of the Bipartisan Budget Act of 2018, under section 205 of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), the MDH program authorized by section 1886(d)(5)(G) of the Act was set to expire at the end of FY 2017.

In the FY 2016 interim final rule with comment period (80 FR 49596 through 49597), we amended the regulations at § 412.108(a)(1) and (c)(2)(iii) to reflect the MACRA extension of the MDH program through FY 2017. 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 2022 provided for by the provisions of the Bipartisan Budget Act of 2018 in future rulemaking.

Since MDH status is now extended by statute through the end of FY 2022, generally, hospitals that previously qualified for MDH status will be reinstated as an MDH retroactively to October 1, 2017. However, in the following two situations, the effective date of MDH status may not be retroactive to October 1, 2017.

1. MDHs that Classified as Sole Community Hospitals (SCHs) on or after October 1, 2017

Under the regulations at § 412.92(b)(2)(v), an MDH could apply for reclassification as a sole community hospital (SCH) by August 31, 2017, in anticipation of the September 30, 2017 expiration of the MDH provision, and have such status be

effective on October 1, 2017. Hospitals that applied by the August 31, 2017 deadline and were approved for SCH classification received SCH status effective October 1, 2017.

Additionally, some hospitals that had MDH status as of the September 30, 2017 expiration of the MDH program may have missed the August 31, 2017 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, 2017. 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 is 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 above may not have its MDH status automatically reinstated effective October 1, 2017. That is, if a provider reclassified to SCH status or cancelled its rural status effective October 1, 2017, its MDH status will not be retroactive to October 1, 2017, 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. However, if a provider reclassified to SCH status or cancelled its rural status effective on a date later than October 1, 2017, MDH status will be reinstated effective from October 1, 2017 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). 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, 2017 expiration of the MDH program:

Example 1: Hospital A was classified as an MDH prior to the September 30, 2017 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, 2017.

Example 2: Hospital B was classified as an MDH prior to the September 30, 2017 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, 2017, and was approved for SCH status effective on October 1, 2017. 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, 2017 expiration of the MDH program. Hospital C missed the application deadline of August 31, 2017 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, 2017. Hospital C's Medicare contractor approved its request for SCH status effective November 16, 2017. Hospital C's MDH status will be reinstated effective October 1, 2017 through November 15, 2017 and will subsequently be cancelled effective November 16, 2017. 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, 2017 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, 2017. 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, 2017 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, 2018. 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, 2018, MDH status will only be reinstated effective October 1, 2017 through December 31, 2017 and will be cancelled effective January 1, 2018. 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, 2017 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 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. As noted previously, we intend to make the conforming changes to the regulations text at 42 CFR 412.108 to reflect the changes made by section 50205 of the Bipartisan Budget Act of 2018 in future rulemaking.

b. Additional Provisions to the MDH Program

In addition to extending the MDH program, section 50205 of the Bipartisan Budget Act also provides for a hospital that is located in a state without a rural area to be eligible to qualify for MDH status if it otherwise satisfies any of the statutory criteria to be reclassified as rural under sections 1886(d)(8)(E)(ii)(I), (II), or (III) of the Act while further specifying that the criteria at sections 1886(d)(8)(E)(ii)(II) of the Act must have been satisfied as of January 1, 2018.

Section 1886(d)(8)(E) of the Act provides for an IPPS hospital that is located in an urban area to be reclassified as a rural hospital if it submits an application in accordance with CMS' established process and meets certain criteria at sections 1886(d)(8)(E)(ii)(I), (II), or (III) of the Act (these statutory criteria are implemented in the regulations at §§412.103(a)(1) through (3)). A subsection (d) hospital that is located in an urban area and meets one of the three criteria under § 412.103(a) can reclassify as rural and is treated as being located in the rural area of the State in which it is located. However, a hospital that is located in an all-urban State is ineligible to reclassify as rural in

accordance with the provisions of § 412.103 because its State does not have a rural area into which it can reclassify. Prior to the amendments made by the Bipartisan Budget Act, a hospital could only qualify for MDH status if it was either geographically located in a rural area or if it reclassified as rural under the regulations at § 412.103. This precluded hospitals in all-urban states from being classified as MDHs. The newly added provision in the Bipartisan Budget Act of 2018 allows a hospital in an all-urban state to be eligible for MDH classification if, in addition to meeting the other criteria for MDH eligibility, it satisfies one of the criteria for rural reclassification under section 1886(d)(8)(E)(ii)(I), (II), or (III) of the Act (as of January 1, 2018 where applicable) notwithstanding its location in an all-urban state.

Under this provision of the Bipartisan Budget Act, a hospital in an all-urban State can apply and be approved for MDH classification if it can demonstrate that: (1) it meets the criteria at § 412.103(a)(1) or (3) or the criteria at § 412.103(a)(2) as of January 1, 2018 for the sole purposes of qualifying for MDH classification and; (2) it meets the MDH classification criteria at §§ 412.108(a)(1)(i) through (iii). We note the following:

- For a hospital in an all-urban State to demonstrate that it would have qualified for rural reclassification notwithstanding its location in an all-urban state (as of January 1, 2018 where applicable), it must follow the applicable procedures for rural reclassification and MDH classification at § 412.103(b) and § 412.108(b), respectively.

- As noted previously, under existing regulations at § 412.108(b)(4), the determination of MDH status is effective 30 days after the date the MAC provides written notification to the hospital.

- A hospital in an all-urban state that qualifies as an MDH under the newly-added statutory provision will not be considered as having reclassified as rural but only as having satisfied one of the criteria at section 1886(d)(8)(E)(ii)(I), (II), or (III) (as of January 1, 2018 as applicable) for purposes of MDH classification, in accordance with amended section 1886(d)(5)(G)(iv) of the Act.

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. Regulatory Impact Analysis

A. Statement of Need

This document is necessary to update the IPPS final FY 2018 payment policies to reflect changes required by the implementation of two provisions of the Bipartisan Budget Act of 2018. Section 50204 of the Bipartisan Budget Act of 2018 extends certain temporary changes to the payment adjustment for low-volume hospitals through FY 2018. Section 50205 of the Bipartisan Budget Act of 2018 extends the MDH program through FY 2022. 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.

B. Overall Impact

We have examined the impacts of this document 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 (March 22, 1995; Pub. L. 104-4), Executive Order 13132 on Federalism (August 4, 1999), the Congressional Review Act (5 U.S.C. 804(2)), and Executive Order 13771 on Reducing Regulation and Controlling Regulatory Costs (January 30, 2017).

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). Section 3(f) of Executive Order 12866 defines a “significant regulatory action” as an action that is likely to result in a rule: (1) having an annual effect on the economy of \$100 million or more in any 1 year, or adversely and materially affecting a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or state, local or tribal governments or communities (also referred to as “economically significant”); (2) creating a serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raising novel legal or policy issues arising out of legal mandates, the President’s priorities, or the principles set forth in the Executive Order.

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 document to constitute a substantive rule or regulatory action, the changes announced in this document 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 the provisions announced in this document.

The FY 2018 IPPS/LTCH PPS final rule in conjunction with the FY 2018 IPPS/LTCH PPS correcting document included an impact analysis for the changes to the IPPS included in that final rule. This document updates those impacts to the IPPS to reflect the changes made by sections 50204 and 50205 of the Bipartisan Budget Act of 2018. Since these sections were not budget neutral, the overall estimates for hospitals have changed from our estimates that were published in the FY 2018 IPPS/LTCH PPS final rule (82 FR 38585) in conjunction with the FY 2018 IPPS/LTCH PPS correcting document (82 FR 46163). We estimate that the changes in the FY 2018 IPPS/LTCH PPS final rule, in conjunction with the changes included in this document, will result in an approximate \$2.97 billion increase in total payments to IPPS hospitals in FY 2018 relative to FY 2017, as described later in this section. In the FY 2018 IPPS/LTCH PPS final rule (82 FR 38585) in conjunction with the FY 2018 IPPS/LTCH PPS correcting document (82 FR 46163), we had projected that total payments to IPPS hospitals would increase by \$2.5 billion relative to FY 2017. However, since the changes in this document are expected to increase payments by approximately \$470 million (\$349 million for the extension of certain temporary changes to the low-volume hospital adjustment policy and \$119 million for the extension of the MDH program) relative to what was projected in the FY 2018 IPPS/LTCH PPS final rule in conjunction with the FY 2018 IPPS/LTCH PPS correcting document, these changes will result in a net increase of \$2.97 billion (\$2.5 billion currently, plus the additional estimated increase of approximately \$0.35 billion for the extension of certain temporary changes to the

low-volume hospital adjustment policy and approximately \$0.12 billion for the extension of the MDH program) in total payments to IPPS hospitals relative to FY 2017.

C. Anticipated Effects

1. Effects on IPPS Hospitals

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 for NAIC 622 at the Small Business Administration's Web site at https://www.sba.gov/sites/default/files/files/Size_Standards_Table.pdf.) 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 the changes announced in this document 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 601(g) of the Social Security Amendments of 1983 (Pub. L. 98–21) designated hospitals in certain New England counties as belonging to the adjacent urban area. Thus, for purposes of the IPPS, we continue to classify these hospitals as urban hospitals.

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 2017, that threshold is approximately \$148 million. This document 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 document will not have a substantial effect on State and local governments.

Although this document merely reflects the implementation of two provisions of the Bipartisan Budget Act of 2018 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 document 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 changes announced in this document 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, is presented in this section.

The impact analysis reflects the change in estimated payments to IPPS hospitals in FY 2018 due to sections 50204 and 50205 of the Bipartisan Budget Act of 2018 relative to estimated FY 2018 payments to IPPS hospitals published in the FY 2018 IPPS/LTCH PPS final rule (82 FR 38585) and in conjunction with the FY 2018 IPPS/LTCH PPS correction notice (82 FR 46163). As described later in this section in the regulatory impact analysis, FY 2018 IPPS payments to hospitals affected by sections 50204 and 50205 of the Bipartisan Budget Act of 2018 are projected to increase by \$468 million (\$349 million for the extension of certain temporary changes to the low-volume hospital adjustment policy and \$119 million for the extension of the MDH program) (relative to the FY 2018 payments estimated for these hospitals for the FY 2018 IPPS/LTCH PPS final rule and in conjunction with the FY 2018 IPPS/LTCH PPS correcting document). Furthermore, we project that, on the average, overall IPPS payments in FY 2018 for all hospitals will increase by 0.4 percent due to these provisions in the Bipartisan Budget Act of 2018 compared to the previous estimate of FY 2018 payments to all IPPS hospitals published in the FY 2018 IPPS/LTCH PPS final rule in conjunction with the FY 2018 IPPS/LTCH PPS correcting document.

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

The extension, for FY 2018, 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 by subsequent legislation) as provided for under Section 50204 of the Bipartisan Budget Act of 2018 is a non-budget neutral payment provision. The provisions of the Affordable Care Act and subsequent legislation expanded the definition of low-volume hospital and modified the methodology for determining the payment adjustment for hospitals meeting that definition for FYs 2011 through 2017. Prior to the enactment of the Bipartisan Budget Act of 2018, beginning with FY 2018, 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 extension for FY 2018 provided for by the Bipartisan Budget Act of 2018, based on FY 2016 claims data (March 2017 update of the MedPAR file), we estimate that approximately 600 hospitals will now qualify as a low-volume hospital for FY 2018. We project that these hospitals will experience an increase in payments of approximately \$349 million as compared to our previous estimates of payments to these hospitals for FY 2018 published in the FY 2018 IPPS/LTCH PPS final rule in conjunction with the FY 2018 IPPS/LTCH PPS correcting document.

3. Effects of the Extension of the MDH Program

The extension of the MDH program in FY 2018 as provided for under section 50205 of the Bipartisan Budget Act of 2018 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 159 MDHs, of which 96 were estimated to be paid under the blended payment of the Federal standardized amount and hospital-specific rate in FY 2017. Because those 96 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 2018, we estimate that those hospitals will experience an overall increase in payments of approximately \$119 million as compared to our previous estimates of payments to these hospitals for FY 2018 published in the FY 2018 IPPS/LTCH PPS final rule in conjunction with the FY 2018 IPPS/LTCH PPS correcting document.

D. Alternatives Considered

This document 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.

E. 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 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 document. All expenditures are classified as transfers from the Federal government to Medicare providers. As previously discussed, relative to what was projected in the FY 2018 IPPS/LTCH PPS final rule in conjunction with the FY 2018 IPPS/LTCH PPS correcting document, the changes made by sections 50204 and 50205 of the Bipartisan Budget Act of 2018 presented in this document are projected to increase FY 2018 payments to IPPS hospitals by \$468 million.

TABLE I. ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES UNDER THE IPPS FROM PUBLISHED FY 2018 TO REVISED FY 2018

Category	Transfers
Annualized Monetized Transfers	\$468 million
From Whom to Whom	Federal Government to IPPS Medicare Providers
Total	\$468 million

F. Regulatory Reform Analysis under E.O. 13771

Executive Order 13771, entitled “Reducing Regulation and Controlling Regulatory Costs,” was issued on January 30, 2017, and requires that the costs associated with significant new regulations “shall, to the extent permitted by law, be offset by the elimination of existing costs associated with at least two prior regulations.” It has been determined that the provisions of this document are actions that primarily result in transfers and do not impose more than de minimis cost as described previously. Thus, this document is not a regulatory or deregulatory action for the purposes of Executive Order 13771.

G. Conclusion

Overall, IPPS hospitals are projected to experience an increase in estimated payments of \$468 million as a result of the changes made by sections 50204 and 50205 of the Bipartisan Budget Act of 2018 presented in this document. The analysis above, together with the preamble, provides a Regulatory Flexibility Analysis. Furthermore, the previous analysis, together with the preamble, provides a Regulatory Impact Analysis. In accordance with the provisions of Executive Order 12866, this document was reviewed by the Office of Management and Budget.

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 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 document do not constitute agency rulemaking. Rather, the statute, as amended by the Bipartisan Budget Act of 2018, has already required that the agency make these changes, and we are simply notifying the public of the extension of certain temporary changes to the payment adjustment for low-volume hospitals and the MDH program for FY 2018, that is effective October 1, 2017. As this document 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 document constitute interpretations of the statute's requirements or procedures that will be used to implement the statute'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 document does not propose to make any substantive changes to the policies or methodologies already in effect as a matter of law, but simply applies payment adjustments under the Bipartisan Budget Act of 2018 to these existing policies and methodologies. As the changes outlined in this document 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 Bipartisan Budget Act of 2018. 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.

Dated: March 29, 2018

Seema Verma,

Administrator,

Centers for Medicare & Medicaid Services.