

EXHIBIT A



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Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System and Proposed Fiscal Year 2014 Rates; Quality Reporting Requirements for Specific Providers; Hospital Conditions of Participation; Medicare Program; FY 2014 Hospice Wage Index and Payment Rate Update; Hospice Quality Reporting Requirements; and Updates on Payment Reform; Proposed Rules

Medicare inpatient days to its *total* inpatient days, we believe that revising the ratio to include labor and delivery days is appropriate because they are inpatient days and therefore should be counted as such. We are proposing to include labor and delivery days as inpatient days in the Medicare utilization calculation effective for cost reporting periods beginning on or after October 1, 2013.

h. Proposed Changes to the DSH Payment Adjustment and the Provision of Additional Payment for Uncompensated Care

Section 3133 of the Affordable Care Act modified the Medicare disproportionate share hospital (DSH) payment methodology beginning in FY 2014. Currently, Medicare DSHs qualify for a DSH payment adjustment under a statutory formula that considers their Medicare utilization due to beneficiaries who also receive Supplemental Security Income benefits and their Medicaid utilization. Under section 1886(r) of the Act, which was added by section 3133 of the Affordable Care Act, starting in FY 2014, DSHs will receive 25 percent of the amount they previously would have received under the current statutory formula for Medicare DSH payments. The remaining amount, equal to 75 percent of what otherwise would have been paid as Medicare DSH payments, will be paid as additional payments after the amount is reduced for changes in the percentage of individuals that are uninsured. Each Medicare DSH will receive its additional amount based on its share of the total amount of uncompensated care for all Medicare DSH hospitals for a given time period. In this proposed rule, we are proposing to implement these statutory changes.

i. Proposal Relating to Admission and Medical Review Criteria for Hospital Inpatient Services Under Medicare Part A

To reduce uncertainty regarding the requirements for payments to hospitals and CAHs under Medicare Part A related to when a Medicare beneficiary should be admitted as a hospital inpatient, in this proposed rule, we are proposing to clarify the rules governing physician orders of hospital inpatient admissions for payment under Medicare Part A. We are proposing to clarify and specify in the regulations that an individual becomes an inpatient of a hospital, including a critical access hospital, pursuant to an order for inpatient admission by a physician or other qualified practitioner and, therefore, the order is required for

payment of hospital inpatient services under Medicare Part A. We are proposing that hospital inpatient admissions spanning 2 midnights in the hospital would generally qualify as appropriate for payment under Medicare Part A. This would revise our guidance to hospitals and physicians relating to when hospital inpatient admissions are determined reasonable and necessary for payment under Part A. We also are proposing to use our exceptions and adjustments authority under section 1886(d)(5)(I)(i) of the Act to offset the additional IPPS expenditures under this proposal by reducing the standardized amount, the hospital-specific amount, and the Puerto Rico-specific standardized amount by 0.2 percent.

j. Proposed LTCH PPS Standard Federal Rate

In section VIII.A. of the preamble of this proposed rule, we present the proposed LTCH PPS standard Federal rate for FY 2014, which includes a proposed adjustment factor of 0.98734 for the second year of the 3-year phase-in of the permanent one-time adjustment to the standard Federal rate. In addition, under the LTCH Quality Reporting (LTCHQR) Program, the proposed annual update to the standard Federal rate will be reduced by 2 percentage points for LTCHs that fail to submit data for FY 2014 on specific measures under section 3004 of the Affordable Care Act.

k. Expiration of Certain Payment Rules for LTCH Services and Research on the Development of a Patient Criteria-Based Payment Adjustment Under the LTCH PPS

In section VIII.D. of the preamble of this proposed rule, we note the expiration of the moratorium on the full implementation of the “25 percent threshold” payment adjustment to LTCHs under the LTCH PPS for cost reporting periods beginning on or after October 1, 2013.

In section VIII.E. of the preamble of this proposed rule, we describe the results of research being done by a CMS contractor, Kennell and Associates (Kennell) and its subcontractor, Research Triangle Institute, International (RTI), on the development of a payment adjustment under the LTCH PPS based on the establishment of LTCH patient criteria.

l. Hospital Inpatient Quality Reporting (IQR) Program

Under section 1886(b)(3)(B)(viii) of the Act, hospitals are required to report data on measures selected by the

Secretary for the Hospital IQR Program in order to receive the full annual percentage increase. In past rules, we have established measures for reporting and the process for submittal and validation of the data.

In this proposed rule, we are proposing to make several changes to: (1) The measure set, including the removal of some measures, the refinement of some measures, and the adoption of several new measures; (2) the administrative processes; and (3) the validation methodologies. We also are proposing to allow hospitals the option of reporting the measures in four measure sets electronically for the FY 2016 payment determination. These proposed changes would improve the timeliness and efficiency of the Hospital IQR Program and begin the process of incorporating electronic reporting into the Hospital IQR Program.

3. Summary of Costs and Benefits

• Proposed Adjustment for MS-DRG Documentation and Coding Changes.

We are proposing a –0.8 percent recoupment adjustment to the standardized amount for FY 2014 to implement, in part, the requirement of section 631 of the ATRA that the Secretary make an adjustment totaling \$11 billion over a 4-year period of FYs 2014, 2015, 2016, and 2017. This recoupment adjustment represents the amount of the increase in aggregate payments as a result of not completing the prospective adjustment authorized under section 7(b)(1)(A) of Public Law 110–90 until FY 2013. Prior to the ATRA, this amount could not have been recovered under Public Law 110–90.

While our actuaries estimate that a –9.3 percent recoupment adjustment to the standardized amount would be necessary if CMS were to fully recover the \$11 billion recoupment required by section 631 of the ATRA in FY 2014, it is often our practice to delay or phase in rate adjustments over more than one year, in order to moderate the effects on rates in any one year. Therefore, consistent with the policies that we have adopted in many similar cases, we are proposing a –0.8 percent recoupment adjustment to the standardized amount in FY 2014. We estimate that this level of adjustment would recover \$0.96 billion in FY 2014, with approximately \$10.4 billion remaining to be addressed. We are not proposing any future adjustments at this time but note that if recoupment adjustments of approximately –0.8 percent are implemented in FYs 2014, 2015, 2016, and 2017, we estimate that the entire \$11 billion will be recovered

by the end of the statutory 4-year timeline.

- **Proposed Refinement of the MS-DRG Relative Weight Calculation.** We refer readers to section VI.C. of Appendix A of this proposed rule for the overall IPPS operating impact, which includes the impact for the proposed refinement of the MS-DRG relative weight calculation. This proposed impact models payments to various hospital types using relative weights developed from 19 CCRs as compared to 15 CCRs. As with other proposed changes to the MS-DRGs, these proposed changes are to be implemented in a budget neutral manner.

- **Proposed Rebasement and Revision of the Hospital Market Baskets for Acute Care Hospitals.** The proposed FY 2010-based IPPS market basket update (as measured by percentage increase) for FY 2014 is currently forecasted to be the same as the market basket update based on the FY 2006-based IPPS market basket at 2.5 percent (currently used under the IPPS). Therefore, we are projecting that there would be no fiscal impact on the IPPS operating payment rates in FY 2014 as a result of the proposed rebasing and revision of the IPPS market basket.

The proposed FY 2010-based IPPS capital input price index update (as measured by percentage increase) for FY 2014 is currently forecasted to be 1.2 percent, 0.2 percentage points lower than the update based on the FY 2006-based capital input price index. Therefore, we are projecting that there would be a fiscal impact of -\$16 million to the IPPS capital payments in FY 2014 as a result of this proposal (0.2 percentage points * annual capital IPPS payments of approximately \$8 billion).

In addition, we are proposing to update the labor-related share under the IPPS for FY 2014 based on the proposed FY 2010-based IPPS market basket, which would result in a labor-related share of 69.6 percent (compared to the FY 2013 labor-related share of 68.8) or 62 percent, depending on which results in higher payments to the hospital. For FY 2014, the proposed labor-related share for the Puerto Rico-specific standardized amount would be either 63.2 percent or 62 percent, depending on which results in higher payments to the hospital. We are projecting that there would be no impact on aggregate IPPS payments as a result of this proposal due to the statutory requirement that any changes to the IPPS area wage adjustment (including the labor-related share) are adopted in a budget neutral manner.

- **Reduction to Hospital Payments for Excess Readmissions.** The provisions of section 1886(q) of the Act which establishes the Hospital Readmissions Reduction Program are not budget neutral. For FY 2014, a hospital's readmissions payment adjustment factor is the higher of a ratio of a hospital's aggregate payments for excess readmissions to its aggregate payments for all discharges, or 0.98 (that is, or a 2-percent reduction). In this proposed rule, we estimate that the reduction to a hospital's base operating DRG payment amount to account for excess readmissions of selected applicable conditions under the Hospital Readmissions Reduction Program will result in a 0.2 percent decrease, or approximately -\$175 million, in payments to hospitals for FY 2014.

- **Value-Based Incentive Payments Under the Hospital Value-Based Purchasing (VBP) Program.** We estimate that there will be no net financial impact to the Hospital VBP Program for FY 2014 in the aggregate because, by law, the amount available for value-based incentive payments under the program in a given fiscal year must be equal to the total amount of base operating DRG payment amount reductions for that year, as estimated by the Secretary. The estimated amount of base operating DRG payment amount reductions for FY 2014, and therefore the estimated amount available for value-based incentive payments for FY 2014 discharges, is approximately \$1.1 billion. We believe that the program's benefits will be seen in improved patient outcomes, safety, and in the patient's experience of care. We intend to provide an updated analysis of the program's estimated dollar impact for the FY 2014 program year in the FY 2014 IPPS/LTCH PPS final rule. However, we cannot estimate these benefits in actual dollar and patient terms.

- **Implementation of the HAC Reduction Program for FY 2014.** We note that there is no payment impact for FY 2014 for implementing the HAC Reduction Program. For FY 2015, we are presenting the overall impact of the HAC Reduction Program provision along with other IPPS payment provision impacts in section I.G. of Appendix A of this proposed rule.

- **Counting of Inpatient Days in the Medicare Utilization Calculation.** We believe our proposal to include labor and delivery days as inpatient days in the Medicare utilization calculation would result in a savings of approximately \$15 million for FY 2014.

- **Changes to the Medicare DSH Payment Adjustment and Provision of**

Additional Payment for Uncompensated Care. Under section 1886(r) of the Act (as added by section 3133 of the Affordable Care Act), disproportionate share payments to hospitals under section 1886(d)(5)(F) of the Act are reduced and an additional payment to eligible hospitals will be made beginning in FY 2014. Hospitals that receive Medicare DSH payments will receive 25 percent of the amount they previously would have received under the current statutory formula for Medicare DSH payments. The remainder, equal to 75 percent of what otherwise would have been paid as Medicare DSH payments, will be the basis for additional payments after the amount is reduced for changes in the percentage of individuals that are uninsured and additional statutory adjustments. Each hospital that receives Medicare DSH payments will receive an additional payment based on its share of the total uncompensated care amount reported by Medicare DSHs. The reduction to Medicare DSH payments is not budget neutral.

We are proposing that 75 percent of what otherwise would have been paid for Medicare DSH payments is adjusted to 88.8 percent of that amount for changes in the percentage of individuals that are uninsured and additional statutory adjustments. In other words, Medicare DSH payments prior to the application of section 3133 are adjusted to 66.6 percent (the product of 75 percent and 88.8 percent) and that resulting payment amount is used to create an additional payment for a hospital's relative uncompensated care. As a result, we project that the reduction of Medicare DSH payments and the inclusion of the additional payments will reduce payments overall by 0.9 percent as compared to Medicare DSH payments prior to the implementation of section 3133. The proposed additional payment costs have redistributive effects based on a hospital's uncompensated care amount relative to the uncompensated care amount for all hospitals that are estimated to receive Medicare DSH payments, and the payment amount is not tied to a hospital's discharges.

- **Proposal Relating to Admission and Medical Review Criteria for Hospital Inpatient Services Under Medicare Part A.** In this proposed rule, we are making a proposal relating to admission and medical review criteria for hospital inpatient admissions under Medicare Part A. One aspect of this proposal is that hospital inpatient admissions spanning 2 midnights in the hospital would generally qualify as appropriate for payment under

Medicare Part A. Our actuaries estimate that the proposal would increase IPPS expenditures by approximately \$220 million due to an expected net increase in inpatient encounters. We are proposing to use our exceptions and adjustments authority under section 1886(d)(5)(I)(i) of the Act to make a reduction of 0.2 percent to the standardized amount, the Puerto Rico standardized amount, and the hospital-specific payment rate to offset this estimated \$220 million in additional IPPS expenditures. We also are proposing to apply that 0.2 percent reduction to the capital Federal rates using our authority under section 1886(g) of the Act.

• **Hospital Inpatient Quality Reporting (IQR) Program.** We are proposing that hospitals participating in the Hospital IQR Program will have the option to report a subset of measures electronically in CY 2014 for the FY 2016 payment determination. Under this proposal, hospitals may choose to report the measures in four measure sets electronically or as chart-abstracted measures in CY 2014. For the FY 2016 payment determination, we also are proposing to remove seven chart-abstracted measures and one structural measure. We also are proposing to adopt five new claims-based measures for the FY 2016 payment determination and subsequent years. We are proposing, for the FY 2016 payment determination and subsequent years, to validate two additional chart-abstracted HAI measures: MRSA *bacteremia*, and *C. difficile*. We also are proposing to reduce the number of records used for HAI validation from 48 records per year to 36 records per year beginning with the FY 2015 payment determination. Finally, we are proposing to allow hospitals to submit patient charts for purposes of validation either in paper form or by means of electronic transmission. We believe the proposed changes to the measure set, processes, and validation methodologies, the proposal for electronic submission of records for validation, as well as the proposal to allow hospitals to report certain measures electronically for the FY 2016 payment determination will result in improved program efficiency and begin the process of incorporating electronic reporting into the program. We estimate that the combination of these proposed changes and the reduction in measures mentioned above will reduce burden hours by 700,000 hours annually.

• **Proposed Update to the LTCH PPS Standard Federal Rate and Other Payment Factors.** Based on the best available data for the 423 LTCHs in our

database, we estimate that the proposed changes we are presenting in the preamble and Addendum of this proposed rule, including the proposed update to the standard Federal rate for FY 2014, the proposed changes to the area wage adjustment for FY 2014, and the proposed changes to short-stay outliers and high-cost outliers, would result in an increase in estimated payments from FY 2013 of approximately \$62 million (or 1.1 percent). Although we generally project an increase in proposed payments for all LTCHs in FY 2014 as compared to FY 2013, we expect rural LTCHs to experience slightly lower increases than the national average due to decreases in their wage index for FY 2014 compared to FY 2013. In addition, under current law, our moratoria on the full implementation of the “25-percent threshold” payment adjustment policy will expire for certain LTCHs for cost reporting periods beginning on or after October 1, 2013. These regulatory moratoria extended, for an additional year, the 5-year statutory moratorium on the application of the “25-percent threshold” payment adjustment policy as provided by section 114(c) of the MMSEA, as amended by section 4302(a) of the ARRA and sections 3106(a) and 10312(a) of the Affordable Care Act, which expired for cost reporting periods beginning on or after October 1, 2012 (“October LTCHs”), and for other LTCHs and LTCH satellite facilities for cost reporting periods beginning on or after July 1, 2012 (“July LTCHs”) (77 FR 53483 through 53484, as amended by the FY 2013 IPPS/LTCH PPS correcting amendment (77 FR 63751 through 63753)), as explained in section VIII.D. of the preamble of this proposed rule. We estimate that the expiration of the regulatory moratoria will result in a reduction in payments of \$190 million to LTCHs. Overall, we estimate that the effect of the changes we are proposing for FY 2014 in conjunction with the expiration of the regulatory moratoria would result in a decrease in aggregate LTCH PPS payments in FY 2014 relative to FY 2013 of approximately –\$128 million (that is, the estimated increase of \$62 million plus the estimated reduction of \$190 million, as described above).

B. Summary

1. Acute Care Hospital Inpatient Prospective Payment System (IPPS)

Section 1886(d) of the Social Security Act (the Act) sets forth a system of payment for the operating costs of acute care hospital inpatient stays under Medicare Part A (Hospital Insurance)

based on prospectively set rates. Section 1886(g) of the Act requires the Secretary to use a prospective payment system (PPS) to pay for the capital-related costs of inpatient hospital services for these “subsection (d) hospitals.” Under these PPSs, Medicare payment for hospital inpatient operating and capital-related costs is made at predetermined, specific rates for each hospital discharge. Discharges are classified according to a list of diagnosis-related groups (DRGs).

The base payment rate is comprised of a standardized amount that is divided into a labor-related share and a nonlabor-related share. The labor-related share is adjusted by the wage index applicable to the area where the hospital is located. If the hospital is located in Alaska or Hawaii, the nonlabor-related share is adjusted by a cost-of-living adjustment factor. This base payment rate is multiplied by the DRG relative weight.

If the hospital treats a high percentage of certain low-income patients, it receives a percentage add-on payment applied to the DRG-adjusted base payment rate. This add-on payment, known as the disproportionate share hospital (DSH) adjustment, provides for a percentage increase in Medicare payments to hospitals that qualify under either of two statutory formulas designed to identify hospitals that serve a disproportionate share of low-income patients. For qualifying hospitals, the amount of this adjustment varies based on the outcome of the statutory calculations.

If the hospital is an approved teaching hospital, it receives a percentage add-on payment for each case paid under the IPPS, known as the indirect medical education (IME) adjustment. This percentage varies, depending on the ratio of residents to beds.

Additional payments may be made for cases that involve new technologies or medical services that have been approved for special add-on payments. To qualify, a new technology or medical service must demonstrate that it is a substantial clinical improvement over technologies or services otherwise available, and that, absent an add-on payment, it would be inadequately paid under the regular DRG payment.

The costs incurred by the hospital for a case are evaluated to determine whether the hospital is eligible for an additional payment as an outlier case. This additional payment is designed to protect the hospital from large financial losses due to unusually expensive cases. Any eligible outlier payment is added to the DRG-adjusted base payment rate, plus any DSH, IME, and new technology or medical service add-on adjustments.

provided on a continuous basis throughout the hospital stay and the services could have been furnished in a shorter timeframe). Beneficiaries should not be held in the hospital absent medically necessary care for the purpose of meeting the 2-midnight presumption.

Patient status reviews for those admissions with lengths of stay greater than 2 midnights would typically be conducted if CMS suspects that a provider is using the time-based presumption to effectuate systematic abuse or gaming. Review contractors would continue to assess claims in which the beneficiary span of care crossed the 2-midnight threshold:

- To ensure the services provided were medically necessary;
- To validate provider coding and documentation as reflective of the medical evidence;
- If the CERT Contractor is directed to do so under the Improper Payments Elimination and Recovery Improvement Act of 2012 (Pub. L. 112–248); or
- If directed by CMS or other authoritative governmental entity (including but not limited to the HHS Office of Inspector General and Government Accountability Office).

As a result of the proposed admission guidelines above, we are proposing that medical review efforts will focus on those inpatient hospital admissions with lengths of stay crossing only only 1midnight or less (that is, only 1 Medicare utilization day, as defined in 42 CFR 409.61 and implemented in the Medicare Benefit Policy Manual, Chapter 3, Section 20.1). As we noted earlier, such claims have traditionally demonstrated the largest proportion of inpatient hospital improper payments under Medicare Part A. If the physician admits the beneficiary as an inpatient but the beneficiary is in the hospital for less than 2 midnights after admission, we are proposing that CMS and its medical review contractors would review the inpatient admission in accordance with current policy for Part A payment, as clarified below, and would not presume that the inpatient hospital admission was reasonable and necessary for payment purposes. Medicare review contractors would evaluate the physician order for inpatient admission to the hospital, the medical documentation supporting that order, and the physician certification in order to determine whether payment under Part A is appropriate.

The Medicare review contractors would consider, in their review of the medical record, complex medical factors that support a reasonable expectation of the needed duration of the stay relative

to the 2-midnight threshold. These factors include such things as beneficiary medical history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event. In other words, if it was reasonable for the physician to expect the beneficiary to require a stay lasting 2 midnights, even though that did not transpire, payment would be made under Medicare Part A if the documentation in the medical record reflected such complex medical factors (and the physician's order and certification requirements also are met). As discussed above, payment may be made in the case of services on Medicare's inpatient only list and in exceptional cases such as beneficiary death or transfer.

4. Proposed Payment Adjustment

The accurate determination of a beneficiary's patient status is an issue of concern across hospitals. As we discuss in section V.N.1. of the preamble of this proposed rule, in the CY 2013 OPPI/ASC proposed rule, we sought comment on actions that we could potentially undertake to address stakeholders' concerns. We received approximately 350 public comments on this issue in response to our solicitation from hospitals and hospital associations, physician associations, rehabilitative and long-term care facilities, beneficiaries, beneficiary advocacy organizations, Quality Improvement Organizations (QIOs), organizations specializing in medical necessity review, and other interested parties. In particular, as stated in the CY 2013 OPPI/ASC final rule with comment period (77 FR 68429) and discussed further in section V.N.1. of the preamble of this proposed rule, we heard from some stakeholders who specifically suggested a need for us to clarify our current instructions regarding the circumstances under which Medicare will pay for a hospital inpatient admission in order to improve hospitals' ability to make appropriate admission decisions.

The issue also has a substantial impact on improper payments under Medicare Part A for short-stay inpatient hospital claims. As discussed earlier, the majority of improper payments under Medicare Part A for short-stay inpatient hospital claims have been due to inappropriate patient status (that is, the services furnished were reasonable and necessary, but should have been furnished on a hospital outpatient, rather than hospital inpatient, basis.) In 2012, the CERT contractor found that inpatient hospital admissions for 1-day stays or less had a Part A improper

payment rate of 36.1 percent. The improper payment rate decreases significantly for 2-day or 3-day stays, which had improper payment rates of 13.2 percent and 13.1 percent, respectively. We believe the magnitude of these national figures demonstrates that the appropriate determination of a beneficiary's patient status is a systemic and widespread issue and is not isolated to a few hospitals. We also note that the RAs have recovered more than \$1.6 billion in improper payments because of inappropriate beneficiary patient status.

Our actuaries have estimated that our proposed policy that medical review of inpatient admissions will include a presumption that hospital inpatient admissions are reasonable and necessary for beneficiaries who require more than 1 Medicare utilization day (defined by encounters crossing 2 "midnights") in the hospital receiving medically necessary services, as discussed in section V.N.3. of the preamble of this proposed rule, would increase IPPS expenditures by approximately \$220 million. These additional expenditures result from an expected net increase in hospital inpatient encounters due to some encounters spanning more than 2 midnights moving to the IPPS from the OPPI, and some encounters of less than 2 midnights moving from the IPPS to the OPPI. Specifically, our actuaries examined FY 2009 through FY 2011 Medicare claims data for extended hospital outpatient encounters and shorter stay hospital inpatient encounters and estimated that approximately 400,000 encounters would shift from outpatient to inpatient and approximately 360,000 encounters would shift from inpatient to outpatient, causing a net shift of 40,000 encounters. These estimated shifts of 400,000 encounters from outpatient to inpatient and 360,000 encounters from inpatient to outpatient represent a significant portion of the approximately 11 million encounters paid under the IPPS. The net shift of 40,000 encounters represents an increase of approximately 1.2 percent in the number of shorter stay hospital inpatient encounters paid under the IPPS. Since shorter stay hospital inpatient encounters currently represent approximately 17 percent of the IPPS expenditures, our actuaries estimated that 17 percent of IPPS expenditures would increase by 1.2 percent under our proposed policy. These additional expenditures are partially offset by reduced expenditures from the shift of shorter stay hospital inpatient encounters to hospital outpatient encounters. Our actuaries estimated that

on average the per encounter payments for these hospital outpatient encounters would be approximately 30 percent of the per encounter payments for the hospital inpatient encounters.

In light of the widespread impact of the proposed policy discussed in section V.N.3. of the preamble of this proposed rule on the IPPS and the systemic nature of the issue as demonstrated above, we believe it is appropriate to propose to use our exceptions and adjustments authority under section 1886(d)(5)(I)(i) of the Act to offset the estimated \$220 million in additional IPPS expenditures associated with this proposed policy. This special exceptions and adjustment authority authorizes us to provide “for such other exceptions and adjustments to [IPPS] payment amounts . . . as the Secretary deems appropriate.” We are proposing to reduce the standardized amount, the hospital-specific rates, and the Puerto Rico-specific standardized amount by 0.2 percent.

VI. Proposed Changes to the IPPS for Capital-Related Costs

A. Overview

Section 1886(g) of the Act requires the Secretary to pay for the capital-related costs of inpatient acute hospital services “in accordance with a prospective payment system established by the Secretary.” Under the statute, the Secretary has broad authority in establishing and implementing the IPPS for acute care hospital inpatient capital-related costs. The IPPS for capital-related costs was initially implemented in the Federal fiscal year (FY) 1992 IPPS final rule (56 FR 43358), in which we established a 10-year transition period to change the payment methodology for Medicare hospital inpatient capital-related costs from a reasonable cost-based methodology to a prospective methodology (based fully on the Federal rate).

FY 2001 was the last year of the 10-year transition period established to phase in the IPPS for hospital inpatient capital-related costs. For cost reporting periods beginning in FY 2002, capital IPPS payments are based solely on the Federal rate for almost all acute care hospitals (other than hospitals receiving certain exception payments and certain new hospitals). (We refer readers to the FY 2002 IPPS final rule (66 FR 39910 through 39914) for additional information on the methodology used to determine capital IPPS payments to hospitals both during and after the transition period.)

The basic methodology for determining capital prospective

payments using the Federal rate is set forth in § 412.312 of the regulations. For the purpose of calculating capital payments for each discharge, the standard Federal rate is adjusted as follows:

$$\text{(Standard Federal Rate)} \times \text{(DRG Weight)} \times \text{(Geographic Adjustment Factor (GAF))} \times \text{(COLA for hospitals located in Alaska and Hawaii)} \times (1 + \text{Capital DSH Adjustment Factor} + \text{Capital IME Adjustment Factor, if applicable}).$$

In addition, under § 412.312(c), hospitals also may receive outlier payments under the capital IPPS for extraordinarily high-cost cases that qualify under the thresholds established for each fiscal year.

B. Additional Provisions

1. Exception Payments

The regulations at § 412.348 provide for certain exception payments under the capital IPPS. The regular exception payments provided under §§ 412.348(b) through (e) were available only during the 10-year transition period. For a certain period after the transition period, eligible hospitals may have received additional payments under the special exceptions provisions at § 412.348(g). However, FY 2012 was the final year hospitals could receive special exceptions payments. For additional details regarding these exceptions policies, we refer readers to the FY 2012 IPPS/LTCH PPS final rule (76 FR 51725).

Under § 412.348(f), a hospital may request an additional payment if the hospital incurs unanticipated capital expenditures in excess of \$5 million due to extraordinary circumstances beyond the hospital’s control. Additional information on the exception payment for extraordinary circumstances in § 412.348(f) can be found in the FY 2005 IPPS final rule (69 FR 49185 and 49186).

2. New Hospitals

Under the capital IPPS, § 412.300(b) of the regulations defines a new hospital as a hospital that has operated (under previous or current ownership) for less than 2 years and lists examples of hospitals that are not considered new hospitals. In accordance with § 412.304(c)(2), under the capital IPPS a new hospital is paid 85 percent of its allowable Medicare inpatient hospital capital-related costs through its first 2 years of operation, unless the new hospital elects to receive full prospective payment based on 100 percent of the Federal rate. We refer readers to the FY 2012 IPPS/LTCH PPS final rule (76 FR 51725) for additional

information on payments to new hospitals under the capital IPPS.

3. Hospitals Located in Puerto Rico

Section 412.374 of the regulations provides for the use of a blended payment amount for prospective payments for capital-related costs to hospitals located in Puerto Rico. Accordingly, under the capital IPPS, we compute a separate payment rate specific to Puerto Rico hospitals using the same methodology used to compute the national Federal rate for capital-related costs. In general, hospitals located in Puerto Rico are paid a blend of the applicable capital IPPS Puerto Rico rate and the applicable capital IPPS Federal rate. Capital IPPS payments to hospitals located in Puerto Rico are computed based on a blend of 25 percent of the capital IPPS Puerto Rico rate and 75 percent of the capital IPPS Federal rate. For additional details on capital IPPS payments to hospitals located in Puerto Rico, we refer readers to the FY 2012 IPPS/LTCH PPS final rule (76 FR 51725).

C. Other Proposed Changes for FY 2014—Proposed Adjustment to Offset the Cost of the Policy Proposal on Admission and Medical Review Criteria for Hospital Inpatient Services Under Medicare Part A

In the Medicare Part B Inpatient Billing in Hospitals proposed rule that went on display at the Office of the Federal Register on March 13, 2013, and that appeared in the **Federal Register** on March 18, 2013 (78 FR 16632), we proposed to revise our Part B inpatient billing policy to allow payment of all hospital services that were furnished and would have been reasonable and necessary if the beneficiary had been treated as an outpatient, rather than admitted to the hospital as an inpatient, except for those services specifically requiring an outpatient status. This policy would apply when CMS or a Medicare review contractor determines that the hospital admission was not reasonable and necessary or when a hospital determines after a beneficiary has been discharged that the beneficiary should have received hospital outpatient services rather than hospital inpatient services. We also proposed to continue applying the timely filing restriction to the billing of all Part B inpatient services, under which claims for Part B services must be filed within 1 year from the date of service. As we discuss in section V.N. of the preamble of this proposed rule, in addition to evaluating our policy related to Medicare Part B inpatient billing following denials of Medicare Part A

inpatient claims on the basis that the inpatient admission was not reasonable and necessary or following a hospital self-audit, we also believe it is important to consider whether we can provide more clarity regarding the relationship between inpatient admission decisions and Medicare payment. Toward that end, we are presenting a proposal that would clarify that a beneficiary becomes a hospital inpatient when formally admitted following the physician order for hospital inpatient admission, and would also clarify when we believe hospital inpatient admissions are reasonable and necessary based on how long beneficiaries have spent, or are reasonably expected to spend, in the hospital as inpatients. Under this proposal, Medicare's external review contractors would presume that hospital inpatient admissions are reasonable and necessary for beneficiaries who require more than one Medicare utilization day (defined by encounters crossing 2 "midnights") in the hospital receiving medically necessary services. Similarly, we would presume that generally services spanning less than 2 midnights should have been provided on an outpatient basis, unless there is clear physician documentation in the medical record supporting the physician's order and expectation that the beneficiary required inpatient care. (For a complete discussion on our proposed inpatient admission guidelines, including our proposed time-based presumption of medical necessity for hospital inpatient services based on the beneficiary's length of stay as part of our medical review criteria for payment of hospital inpatient services under Medicare Part A, we refer readers to section V.N.3 of the preamble of this proposed rule.)

Our actuaries project an increase in IPPS expenditures as a result of our proposed policy that medical review of inpatient admissions will include a presumption that hospital inpatient admissions are reasonable and necessary for beneficiaries who require more than 1 Medicare utilization day (defined by encounters crossing 2 "midnights") in the hospital receiving medically necessary services as discussed in section V.N.3. of the preamble of this proposed rule (and as briefly summarized above). These additional expenditures result from an expected net increase in hospital inpatient encounters due to some encounters spanning more than 2 midnights moving to the IPPS from the OPPS, and some encounters of less than 2 midnights moving from the IPPS to the OPPS. In making this projection, the

actuaries analyzed Medicare claims data for extended hospital outpatient encounters and shorter stay hospital inpatient encounters, and estimated the number of encounters that are expected to shift from outpatient to inpatient and vice versa (that is, the number that are expected to shift from inpatient to outpatient). These estimated shifts of encounters represent a significant portion of the total encounters paid under the IPPS. Our actuaries estimate that this projected net increase in inpatient encounters would increase IPPS expenditures by approximately \$220 million. In light of the widespread impact on the IPPS of our proposed policy and the systemic nature of the issue, we believe it is appropriate to propose to use our exceptions and adjustments authority under section 1886(d)(5)(I)(i) of the Act to offset the estimated \$220 million in additional IPPS expenditures associated with this proposed policy by proposing to apply a -0.2 percent adjustment to the operating IPPS standardized amount, the hospital-specific rates, and the Puerto Rico-specific standardized amount. (For additional information on our actuarial estimate, we refer readers to section V.N.5. of the preamble of this proposed rule.)

Consistent with the proposal that we are making for the operating national and Puerto Rico-specific standardized amounts and the hospital specific-rates, we believe that it is also appropriate, under the Secretary's broad authority under section 1886(g) of the Act, to propose to reduce the national capital Federal rate and Puerto Rico-specific capital rate by 0.2 percent (an adjustment factor of 0.998) to offset the estimated increase in capital IPPS expenditures associated with the projected increase in inpatient encounters that is expected to result from our proposed inpatient admission guidelines. Because hospitals receive an operating IPPS payment and also a capital IPPS payment for each discharge, we believe it would be appropriate to reduce payments under both the operating and capital IPPS to fully offset the projected increase in expenditures associated with these inpatient discharges. (We refer readers to section V.N. of the preamble of this proposed rule for a complete discussion of our policy proposal on inpatient admission guidelines, including our proposed time-based presumption of medical necessity for hospital inpatient services based on the beneficiary's length of stay as part of our medical review criteria for hospital inpatient services under Medicare Part A.)

D. Proposed Annual Update for FY 2014

The proposed annual update to the capital PPS Federal and Puerto Rico-specific rates, as provided for at § 412.308(c), for FY 2014 is discussed in section III. of the Addendum to this proposed rule.

We note that, in section II.D. of the preamble of this proposed rule, we present a discussion of the MS-DRG documentation and coding adjustment, including previously finalized policies and historical adjustments, as well as our proposed recoupment adjustment to the standardized amounts under section 1886(d) of the Act for FY 2014 pursuant to the amendments made to section 7(b)(1)(B) of Public Law 110-90 by section 631 of the ATRA.

Additional prospective adjustments for the MS-DRG documentation and coding effect through FY 2010 authorized under section 1886(d)(3)(A)(vi) of the Act are discussed in section II.D.7. of this preamble. Based on an analysis of FY 2010 data on claims paid through December 2011 using our historical claims-based methodology, we determined an additional prospective documentation and coding effect of +0.8 through FY 2010. Consistent with our proposal for the operating IPPS standardized amounts, in the FY 2013 IPPS/LTCH PPS proposed rule (77 FR 27997), we proposed to reduce the national capital Federal rate in FY 2013 by an additional 0.8 percent to account for the remainder of the cumulative effect of the estimated changes in documentation and coding under the MS-DRG system that did not reflect an increase in case-mix severity through FY 2010. Numerous commenters objected to that proposal, and many commenters continued to assert that our estimates of documentation and coding were overstated, and could be explained by other factors. These commenters also focused on part of the analysis provided by MedPAC in its FY 2012 comment letter indicating that a slightly smaller additional prospective adjustment of -0.55 percent rather than -0.8 percent might be required to offset the cumulative MS-DRG documentation and coding effect through FY 2010. (77 FR 53278 through 53280) Many commenters requested that if CMS were to apply an additional prospective adjustment for the MS-DRG documentation and coding effect through FY 2010, it should subtract 0.25 percentage points from its estimate, for an adjustment of -0.55 percent, given the MedPAC analysis. After consideration of the public comments, we recognized that the issue of the

discharge data and proposed FY 2014 post-reclassified national and Puerto Rico-specific wage indices to simulate IPPS payments. First, we compared the national and Puerto Rico-specific simulated payments without the national rural floor and imputed floor and Puerto Rico-specific rural floor applied to the national and Puerto Rico-specific simulated payments with the national rural floor and imputed floor and Puerto Rico-specific rural floor applied to determine the proposed national rural budget neutrality adjustment factor of 0.990189 and the proposed Puerto Rico-specific budget neutrality adjustment factor of 0.990877. The national adjustment is applied to the national wage indices to produce a national rural floor budget neutral wage index and the Puerto Rico-specific adjustment is applied to the Puerto Rico-specific wage indices to produce a Puerto Rico-specific rural floor budget neutral wage index.

d. Proposed Case-Mix Budget Neutrality Adjustment

Below we summarize the proposed recoupment adjustment to the FY 2014 payment rates, as required by section 631 of ATRA, to account for the increase in aggregate payments as a result of not completing the prospective adjustment authorized under section 7(b)(1)(A) of Public Law 110–90 until FY 2013. We refer readers to section II.D. of the preamble of this proposed rule for a complete discussion regarding our proposals and previously finalized policies (including our historical adjustments to the payment rates) relating to the effect of changes in documentation and coding that do not reflect real changes in case-mix. We note that section II.D. of the preamble of this proposed rule also includes a discussion on documentation and coding effects that occurred through FY 2010, including a request for public comments as to whether any portion of the proposed –0.8 percent recoupment adjustment discussed below should be reduced and instead applied as a prospective adjustment for the cumulative MS–DRG documentation and coding effect through FY 2010.

(1) Recoupment or Repayment Adjustment Authorized by Section 631 of the American Taxpayer Relief Act of 2012 (ATRA) to the National Standardized Amount

Section 631 of the ATRA amended section 7(b)(1)(B) of Public Law 110–90 to require the Secretary to make a recoupment adjustment totaling \$11 billion by FY 2017. Our actuaries estimate that if CMS were to fully account for the \$11 billion recoupment required by section 631 of ATRA in FY 2014, a one time –9.3 percent adjustment to the standardized amount would be necessary. It is often our practice to delay or phase in rate adjustments over more than one year, in order to moderate the effect on rates in any one year. Therefore, consistent with the policies that we have adopted in many similar cases, we are proposing a –0.8 percent adjustment to the standardized amount in FY 2014. We note that, as section 631 of the ATRA instructs CMS to make a recoupment adjustment only to the standardized amount, this proposed adjustment would not apply to the Puerto Rico-specific rate.

e. Proposed Adjustment To Offset the Cost of the Policy Proposal on Admission and Medical Review Criteria for Hospital Inpatient Services Under Medicare Part A

In the Medicare Part B Inpatient Billing in Hospitals proposed rule that went on display at the Office of the Federal Register on March 13, 2013, and that appeared in the **Federal Register** on March 18, 2013 (78 FR 16632), we proposed to revise our Part B inpatient billing policy to allow payment of all hospital services that were furnished and would have been reasonable and necessary if the beneficiary had been treated as an outpatient, rather than admitted to the hospital as an inpatient, except for those services specifically requiring an outpatient status. This policy would apply when CMS or a Medicare review contractor determines that the hospital admission was not reasonable and necessary or when a hospital determines after a beneficiary has been discharged that the beneficiary should have received hospital outpatient services rather than hospital inpatient services. We also proposed to continue applying the timely filing restriction to the billing of all Part B inpatient services, under which claims for Part B services must be filed within 1 year from the date of service. As we discuss in section V.N. of the preamble to this proposed rule, in addition to evaluating our policy related to Part B inpatient billing following denials of Part A inpatient claims on the basis that the inpatient admission was not reasonable and necessary or following self-audit, we also believe it is important to consider whether we can provide more clarity regarding the relationship between inpatient admission decisions and Medicare payment. Toward that end, in section V.N.3. of the preamble of this proposed rule, we present a proposal that would clarify that a beneficiary becomes a hospital inpatient when formally admitted following the physician order for hospital inpatient admission, and would also clarify when we believe hospital inpatient admissions are reasonable and necessary based on how long beneficiaries have spent, or are reasonable expected to spend, in the hospital as inpatients. Under this proposal, Medicare's external review contractors would presume that hospital inpatient admissions are reasonable and necessary for beneficiaries who require more than one Medicare utilization day (defined by encounters crossing 2 “midnights”) in the hospital receiving medically necessary services. Similarly, we would presume that generally services spanning less than 2 midnights should have been provided on an outpatient basis, unless there is clear physician documentation in the medical record supporting the physician's order and expectation that the beneficiary required an inpatient level of care. (For a complete discussion on our proposed inpatient admission guidelines, including our proposed time-based presumption of medical necessity for hospital inpatient services based on the beneficiary's length of stay as part of our medical review criteria for payment of hospital inpatient services under Medicare Part A, we refer readers to section V.N.3 of this proposed rule.)

Our actuaries project a net increase in IPPS expenditures as a result of the proposed policy that medical review of inpatient admissions will include a presumption that hospital inpatient admissions are reasonable and necessary for beneficiaries who require more than 1 Medicare utilization day (defined by encounters crossing 2 “midnights”) in the hospital receiving medically necessary services, discussed in section V.N.3. of the preamble of this proposed rule (as summarized above). These additional expenditures result from an expected net increase in hospital inpatient encounters due to some encounters spanning more than 2 midnights moving to the IPPS from the OPSS, and some encounters of less than 2 midnights moving from the IPPS to the OPSS. In making this projection, the actuaries analyzed Medicare claims data for extended hospital outpatient encounters and shorter stay hospital inpatient encounters, and estimated the number of encounters that are expected to shift from outpatient to inpatient and vice versa (that is, the number that are expected to shift from inpatient to outpatient). In section V.N.5. of the preamble of this proposed rule, we discuss that our actuaries estimate that this projected net increase in inpatient encounters would increase IPPS expenditures by approximately \$220 million. In light of the widespread impact on the IPPS of the proposed policy and the systemic nature of the issue, we believe it is appropriate to use our exceptions and adjustments authority under section 1886(d)(5)(I)(i) of the Act to offset the estimated \$220 million in additional IPPS expenditures associated with this proposed policy by proposing to reduce the national standardized amount, the Puerto Rico-specific standardized amount, and hospital-specific rates by 0.2 percent (or 0.998 adjustment). We refer readers to section V.N.4. of the preamble of this proposed rule for a complete discussion on this proposed adjustment to offset the estimated cost of the proposed time-based presumption of medical necessity for hospital inpatient services based on the beneficiary's length of stay as part of our medical review criteria for hospital inpatient services under Medicare Part A.

f. Proposed Rural Community Hospital Demonstration Program Adjustment

As discussed in section V.K. of the preamble to this proposed rule, section 410A of Public Law 108–173 originally required the Secretary to establish a demonstration program that modifies reimbursement for inpatient services for up to 15 small rural hospitals. Section 410A(c)(2) of Public Law 108–173 requires that “[i]n conducting the demonstration program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration program under this section was not implemented.”

Sections 3123 and 10313 of the Affordable Care Act extended the demonstration program for an additional 5-year period, and allowed up to 30 hospitals to participate in 20 States with low population densities determined by the Secretary. (In determining

Currently, SCHs are paid based on whichever of the following rates yields the greatest aggregate payment: The Federal national rate; the updated hospital-specific rate based on FY 1982 costs per discharge; the updated hospital-specific rate based on FY 1987 costs per discharge; the updated hospital-specific rate based on FY 1996 costs per discharge; or the updated hospital-specific rate based on FY 2006 costs per discharge to determine the rate that yields the greatest aggregate payment.

The prospective payment rate for SCHs for FY 2014 equals the higher of the applicable Federal rate, or the hospital-specific rate as described below. The prospective payment rate for hospitals located in Puerto Rico for FY 2014 equals 25 percent of the Puerto Rico-specific payment rate plus 75 percent of the applicable national rate.

1. Federal Rate

The Federal rate is determined as follows:

Step 1—Select the applicable average standardized amount depending on whether the hospital submitted qualifying quality data (full update for hospitals submitting quality data; update including a –2.0 percent adjustment for hospitals that did not submit these data).

Step 2—Multiply the labor-related portion of the standardized amount by the applicable wage index for the geographic area in which the hospital is located or the area to which the hospital is reclassified.

Step 3—For hospitals in Alaska and Hawaii, multiply the nonlabor-related portion of the standardized amount by the applicable cost-of-living adjustment factor.

Step 4—Add the amount from Step 2 and the nonlabor-related portion of the standardized amount (adjusted, if applicable, under Step 3).

Step 5—Multiply the final amount from Step 4 by the relative weight corresponding to the applicable MS-DRG (Table 5 listed in section VI. of this Addendum and available via the Internet).

The Federal rate as determined in Step 5 may then be further adjusted if the hospital qualifies for either the IME or DSH adjustment. In addition, for hospitals that qualify for a low-volume payment adjustment under section 1886(d)(12) of the Act and 42 CFR 412.101(b), the payment in Step 5 would be increased by the formula described in section V.C. of the preamble of this proposed rule. Finally, the base-operating DRG payment amount may be further adjusted by the hospital readmissions payment adjustment and the hospital VBP payment adjustment as described under sections 1886(q) and 1886(o) of the Act, respectively.

2. Hospital-Specific Rate (Applicable Only to SCHs)

a. Calculation of Hospital-Specific Rate

Section 1886(b)(3)(C) of the Act provides that currently SCHs are paid based on whichever of the following rates yields the greatest aggregate payment: the Federal rate; the updated hospital-specific rate based on FY 1982 costs per discharge; the updated hospital-specific rate based on FY 1987 costs per discharge; the updated hospital-specific rate based on FY 1996 costs per discharge; or

the updated hospital-specific rate based on FY 2006 costs per discharge to determine the rate that yields the greatest aggregate payment. For a more detailed discussion of the calculation of the hospital-specific rates, we refer readers to the FY 1984 IPPS interim final rule (48 FR 39772); the April 20, 1990 final rule with comment period (55 FR 15150); the FY 1991 IPPS final rule (55 FR 35994); and the FY 2001 IPPS final rule (65 FR 47082).

b. Updating the FY 1982, FY 1987, FY 1996 and FY 2006 Hospital-Specific Rate for FY 2013

Section 1886(b)(3)(B)(iv) of the Act provides that the applicable percentage increase applicable to the hospital-specific rates for SCHs equals the applicable percentage increase set forth in section 1886(b)(3)(B)(i) of the Act (that is, the same update factor as for all other hospitals subject to the IPPS). Because the Act sets the update factor for SCHs equal to the update factor for all other IPPS hospitals, the update to the hospital-specific rates for SCHs is subject to the amendments to section 1886(b)(3)(B) of the Act made by sections 3401(a) and 10319(a) of the Affordable Care Act. Accordingly, the proposed applicable percentage increase to the hospital-specific rates applicable to SCHs is 1.8 percent (that is, the FY 2014 estimate of the market basket rate-of-increase of 2.5 percent less a proposed adjustment of 0.4 percentage point for MFP and less 0.3 percentage point) for hospitals that submit quality data or –0.2 percent (that is, the FY 2014 estimate of the market basket rate-of-increase of 2.5 percent, less 2.0 percentage points for failure to submit data under the Hospital IQR Program, less a proposed adjustment of 0.4 percentage point for MFP, and less 0.3 percentage point) for hospitals that fail to submit quality data. For a complete discussion of the applicable percentage increase applicable to the hospital-specific rates for SCHs, we refer readers to section V.A. of the preamble of this proposed rule.

In addition, because SCHs use the same MS-DRGs as other hospitals when they are paid based in whole or in part on the hospital-specific rate, the hospital-specific rate is adjusted by a budget neutrality factor to ensure that changes to the MS-DRG classifications and the recalibration of the MS-DRG relative weights are made in a manner so that aggregate IPPS payments are unaffected. Therefore, a SCH's hospital-specific rate is adjusted by the proposed MS-DRG reclassification and recalibration budget neutrality factor of 0.997583, as discussed in section III. of this Addendum. The resulting rate is used in determining the payment rate an SCH will receive for its discharges beginning on or after October 1, 2013. We note that, in this proposed rule, for FY 2014, we are not proposing to make a documentation and coding adjustment to the hospital-specific rate. We refer readers to section II.D. of the preamble of this proposed rule for a complete discussion regarding our proposals and previously finalized policies (including our historical adjustments to the payment rates) relating to the effect of changes in documentation and coding that do not reflect real changes in case-mix. We note

that section II.D. of the preamble of this proposed rule also includes a discussion on documentation and coding effects that occurred through FY 2010, including a request for public comments as to whether any portion of the proposed –0.8 percent recoupment adjustment discussed in section II.D.6. of the preamble of this proposed rule should be reduced and instead applied as a prospective adjustment for the cumulative MS-DRG documentation and coding effect through FY 2010.

c. Proposed Adjustment To Offset the Cost of the Admission and Medical Review Criteria for Hospital Inpatient Services Under Medicare Part A Proposal and Clarification

As discussed previously, in section V.N.5. of the preamble of this proposed rule, our actuaries project additional IPPS expenditures would result from our proposed policy that medical review of inpatient admissions will include a presumption that hospital inpatient admissions are reasonable and necessary for beneficiaries who require more than 1 Medicare utilization day (defined by encounters crossing 2 “midnights”) in the hospital receiving medically necessary services (which is presented in section V.N.3. of the preamble of this proposed rule). We believe it is appropriate to use our exceptions and adjustments authority under section 1886(d)(5)(I)(i) of the Act to propose reductions of 0.2 percent (or 0.998 adjustment) to the IPPS rates, including the proposed FY 2014 hospital-specific rate for SCHs, to offset our estimate of the increase in IPPS payments. We refer readers to section V.N. of the preamble of this proposed rule for a complete discussion of our policy proposal on admission and medical review criteria for hospital inpatient services under Medicare Part A.

3. General Formula for Calculation of Prospective Payment Rates for Hospitals Located in Puerto Rico Beginning on or After October 1, 2013, and Before October 1, 2014

Section 1886(d)(9)(E)(iv) of the Act provides that, effective for discharges occurring on or after October 1, 2004, hospitals located in Puerto Rico are paid based on a blend of 75 percent of the national prospective payment rate and 25 percent of the Puerto Rico-specific rate.

a. Puerto Rico-Specific Rate

The Puerto Rico-specific prospective payment rate is determined as follows:

Step 1—Select the applicable average standardized amount considering the applicable wage index (obtained from Table 1C published in section VI. of this Addendum and available via the Internet).

Step 2—Multiply the labor-related portion of the standardized amount by the applicable Puerto Rico-specific wage index.

Step 3—Add the amount from Step 2 and the nonlabor-related portion of the standardized amount.

Step 4—Multiply the amount from Step 3 by the applicable MS-DRG relative weight (obtained from Table 5 listed in section VI. of this Addendum and available via the Internet).

Step 5—Multiply the result in Step 4 by 25 percent.

b. National Prospective Payment Rate

The national prospective payment rate is determined as follows:

Step 1—Select the applicable average standardized amount.

Step 2—Multiply the labor-related portion of the standardized amount by the applicable wage index for the geographic area in which the hospital is located or the area to which the hospital is reclassified.

Step 3—Add the amount from Step 2 and the nonlabor-related portion of the national average standardized amount.

Step 4—Multiply the amount from Step 3 by the applicable MS-DRG relative weight (obtained from Table 5 listed in section VI. of this Addendum and available via the Internet).

Step 5—Multiply the result in Step 4 by 75 percent.

The sum of the Puerto Rico-specific rate and the national prospective payment rate computed above equals the prospective payment for a given discharge for a hospital located in Puerto Rico. This rate is then further adjusted if the hospital qualifies for either the IME or DSH adjustment.

c. Proposed Adjustment To Offset the Cost of the Admission and Medical Review Criteria for Hospital Inpatient Services Under Medicare Part A Proposal and Clarification

As discussed previously, in section V.N.5. of the preamble of this proposed rule, our actuaries project additional IPPS expenditures would result from our proposed policy that medical review of inpatient admissions will include a presumption that hospital inpatient admissions are reasonable and necessary for beneficiaries who require more than 1 Medicare utilization day (defined by encounters crossing 2 “midnights”) in the hospital receiving medically necessary services (which is presented in section V.N.3. of the preamble of this proposed rule). We believe it is appropriate to use our exceptions and adjustments authority under section 1886(d)(5)(I)(i) of the Act to propose reductions of 0.2 percent (or 0.998 adjustment) to the IPPS rates, including the FY 2014 national standardized amount and the Puerto Rico standardized amount, to offset our estimate of the increase in IPPS payments. We refer readers to section V.N. of the preamble of this proposed rule for a complete discussion of our policy proposal on admission and medical review criteria for hospital inpatient services under Medicare Part A.

III. Proposed Changes to Payment Rates for Acute Care Hospital Inpatient Capital-Related Costs for FY 2014

The PPS for acute care hospital inpatient capital-related costs was implemented for cost reporting periods beginning on or after October 1, 1991. Effective with that cost reporting period, over a 10-year transition period (which extended through FY 2001) the payment methodology for Medicare acute care hospital inpatient capital-related costs changed from a reasonable cost-based methodology to a prospective methodology (based fully on the Federal rate).

The basic methodology for determining Federal capital prospective rates is set forth

in the regulations at 42 CFR 412.308 through 412.352. Below we discuss the factors that we used to determine the proposed capital Federal rate for FY 2014, which would be effective for discharges occurring on or after October 1, 2013.

The 10-year transition period ended with hospital cost reporting periods beginning on or after October 1, 2001 (FY 2002). Therefore, for cost reporting periods beginning in FY 2002, all hospitals (except “new” hospitals under § 412.304(c)(2)) are paid based on the capital Federal rate. For FY 1992, we computed the standard Federal payment rate for capital-related costs under the IPPS by updating the FY 1989 Medicare inpatient capital cost per case by an actuarial estimate of the increase in Medicare inpatient capital costs per case. Each year after FY 1992, we update the capital standard Federal rate, as provided at § 412.308(c)(1), to account for capital input price increases and other factors. The regulations at § 412.308(c)(2) also provide that the capital Federal rate be adjusted annually by a factor equal to the estimated proportion of outlier payments under the capital Federal rate to total capital payments under the capital Federal rate. In addition, § 412.308(c)(3) requires that the capital Federal rate be reduced by an adjustment factor equal to the estimated proportion of payments for exceptions under § 412.348. (We note that, as discussed in the FY 2013 IPPS/LTCH PPS final rule (77 FR 53705), there is generally no longer a need for an exceptions payment adjustment factor.) However, in limited circumstances, an additional payment exception for extraordinary circumstances is provided for under § 412.348(f) for qualifying hospitals. Therefore, in accordance with § 412.308(c)(3), an exceptions payment adjustment factor may need to be applied if such payments are made. Section 412.308(c)(4)(ii) requires that the capital standard Federal rate be adjusted so that the effects of the annual DRG reclassification and the recalibration of DRG weights and changes in the geographic adjustment factor (GAF) are budget neutral.

Section 412.374 provides for blended payments to hospitals located in Puerto Rico under the IPPS for acute care hospital inpatient capital-related costs. Accordingly, under the capital PPS, we compute a separate payment rate specific to hospitals located in Puerto Rico using the same methodology used to compute the national Federal rate for capital-related costs. In accordance with section 1886(d)(9)(A) of the Act, under the IPPS for acute care hospital operating costs, hospitals located in Puerto Rico are paid for operating costs under a special payment formula. Effective October 1, 2004, in accordance with section 504 of Public Law 108–173, the methodology for operating payments made to hospitals located in Puerto Rico under the IPPS was revised to make payments based on a blend of 25 percent of the applicable standardized amount specific to Puerto Rico hospitals and 75 percent of the applicable national average standardized amount. In conjunction with this change to the operating blend percentage, effective with discharges occurring on or after October 1, 2004, we also revised the methodology for

computing capital payments made to hospitals located in Puerto Rico to be based on a blend of 25 percent of the Puerto Rico capital rate and 75 percent of the national capital Federal rate (69 FR 49185).

A. Determination of the Proposed Federal Hospital Inpatient Capital-Related Prospective Payment Rate Update

In the discussion that follows, we explain the factors that we are proposing to use to determine the capital Federal rate for FY 2014. In particular, we explain why the proposed FY 2014 capital Federal rate would increase approximately 1.5 percent, compared to the FY 2013 capital Federal rate. As discussed in the impact analysis in Appendix A to this proposed rule, we estimate that capital payments per discharge would increase 1.1 percent during that same period. Because capital payments constitute about 10 percent of hospital payments, a percent change in the capital Federal rate yields only about a 0.1 percent change in actual payments to hospitals.

1. Projected Capital Standard Federal Rate Update

a. Description of the Update Framework

Under § 412.308(c)(1), the capital standard Federal rate is updated on the basis of an analytical framework that takes into account changes in a capital input price index (CIPI) and several other policy adjustment factors. Specifically, we adjust the projected CIPI rate-of-increase as appropriate each year for case-mix index-related changes, for intensity, and for errors in previous CIPI forecasts. The proposed update factor for FY 2014 under that framework is 0.9 percent based on the best data available at this time. The proposed update factor under that framework is based on a projected 1.2 percent increase in the proposed revised and rebased FY 2010-based CIPI (discussed in more detail in section IV.D. of the preamble of this proposed rule), a 0.0 percentage point adjustment for intensity, a 0.0 percentage point adjustment for case-mix, a 0.0 percentage point adjustment for the FY 2012 DRG reclassification and recalibration, and a forecast error correction of –0.3 percentage point. As discussed below in section III.C. of this Addendum, we continue to believe that the CIPI is the most appropriate input price index for capital costs to measure capital price changes in a given year. We also explain the basis for the FY 2014 CIPI projection in that same section of this Addendum. Below we describe the policy adjustments that we are proposing to apply in the update framework for FY 2014.

The case-mix index is the measure of the average DRG weight for cases paid under the IPPS. Because the DRG weight determines the prospective payment for each case, any percentage increase in the case-mix index corresponds to an equal percentage increase in hospital payments.

The case-mix index can change for any of several reasons:

- The average resource use of Medicare patients changes (“real” case-mix change);
- Changes in hospital documentation and coding of patient records result in higher-weighted DRG assignments (“coding effects”); and

That is, because the outlier threshold used to identify outlier cases would be higher, cases would receive lower outlier payments and fewer cases would qualify for outlier payments.

The outlier reduction factors are not built permanently into the capital rates; that is, they are not applied cumulatively in determining the capital Federal rate. The proposed FY 2014 outlier adjustment of 0.9451 is a 0.95 percent change from the FY 2013 outlier adjustment of 0.9362. Therefore, the proposed net change in the outlier adjustment to the capital Federal rate for FY 2014 is 1.0095 (0.9451/0.9362). Thus, the proposed outlier adjustment would increase the FY 2014 capital Federal rate by 0.95 percent compared to the FY 2013 outlier adjustment.

3. Proposed Budget Neutrality Adjustment Factor for Changes in DRG Classifications and Weights and the GAF

Section 412.308(c)(4)(ii) requires that the capital Federal rate be adjusted so that aggregate payments for the fiscal year based on the capital Federal rate after any changes resulting from the annual DRG reclassification and recalibration and changes in the GAF are projected to equal aggregate payments that would have been made on the basis of the capital Federal rate without such changes. Because we implemented a separate GAF for Puerto Rico, we apply separate budget neutrality adjustments for the national GAF and the Puerto Rico GAF. We apply the same budget neutrality factor for DRG reclassifications and recalibration nationally and for Puerto Rico. Separate adjustments were unnecessary for FY 1998 and earlier because the GAF for Puerto Rico was implemented in FY 1998.

To determine the proposed factors for FY 2014, we compared (separately for the national capital rate and the Puerto Rico capital rate) estimated aggregate capital Federal rate payments based on the FY 2013 MS-DRG classifications and relative weights and the FY 2013 GAF to estimated aggregate capital Federal rate payments based on the FY 2013 MS-DRG classifications and relative weights and the proposed FY 2014 GAFs. To achieve budget neutrality for the changes in the national GAFs, based on calculations using updated data, we are proposing to apply an incremental budget neutrality adjustment factor of 0.9998 for FY 2014 to the previous cumulative FY 2013 adjustment factor of 0.9904, yielding an adjustment factor of 0.9902 through FY 2014. For the Puerto Rico GAFs, we are proposing to apply an incremental budget neutrality adjustment factor of 0.9990 for FY 2014 to the previous cumulative FY 2013 adjustment factor of 1.0095, yielding a cumulative adjustment factor of 1.0084 through FY 2014.

We then compared estimated aggregate capital Federal rate payments based on the FY 2013 MS-DRG relative weights and the proposed FY 2014 GAFs to estimated aggregate capital Federal rate payments based on the cumulative effects of the proposed FY 2014 MS-DRG classifications and relative weights and the proposed FY 2014 GAFs. The proposed incremental adjustment factor for DRG classifications and changes in relative weights is 0.9990 both nationally and

for Puerto Rico. The proposed cumulative adjustment factors for MS-DRG classifications and proposed changes in relative weights and for proposed changes in the GAFs through FY 2014 are 0.9892 nationally and 1.0074 for Puerto Rico. (We note that all the values are calculated with unrounded numbers.) The GAF/DRG budget neutrality adjustment factors are built permanently into the capital rates; that is, they are applied cumulatively in determining the capital Federal rate. This follows the requirement under § 412.308(c)(4)(ii) that estimated aggregate payments each year be no more or less than they would have been in the absence of the annual DRG reclassification and recalibration and changes in the GAFs.

The methodology used to determine the recalibration and geographic adjustment factor (GAF/DRG) budget neutrality adjustment is similar to the methodology used in establishing budget neutrality adjustments under the IPPS for operating costs. One difference is that, under the operating IPPS, the budget neutrality adjustments for the effect of geographic reclassifications are determined separately from the effects of other changes in the hospital wage index and the MS-DRG relative weights. Under the capital IPPS, there is a single GAF/DRG budget neutrality adjustment factor (the national capital rate and the Puerto Rico capital rate are determined separately) for changes in the GAF (including geographic reclassification) and the MS-DRG relative weights. In addition, there is no adjustment for the effects that geographic reclassification has on the other payment parameters, such as the payments for DSH or IME.

The proposed cumulative adjustment factor accounts for the proposed MS-DRG reclassifications and recalibration and for proposed changes in the GAFs. It also incorporates the effects on the proposed GAFs of FY 2014 geographic reclassification decisions made by the MGCRB compared to FY 2013 decisions. However, it does not account for changes in payments due to changes in the DSH and IME adjustment factors.

4. Proposed Capital Federal Rate for FY 2014

For FY 2013, we established a capital Federal rate of \$425.49 (77 FR 53706). We are proposing to establish an update of 0.9 percent in determining the FY 2014 capital Federal rate for all hospitals. In addition, as discussed in greater detail in section IV.C. of the preamble of this proposed rule, we are proposing to make a reduction of 0.2 percent to the capital IPPS rates, to offset the estimated additional IPPS expenditures that are projected to result from our policy proposal on admission and medical review criteria for hospital inpatient services under Medicare Part A.

As a result of the proposed 0.9 percent update, the proposed budget neutrality factors, and the proposed 0.2 percent reduction to offset the estimated additional IPPS expenditures projected to result from our policy proposal on admission and medical review criteria for hospital inpatient services discussed above, we are proposing to

establish a national capital Federal rate of \$432.03 for FY 2014. The proposed national capital Federal rate for FY 2014 was calculated as follows:

- The proposed FY 2014 update factor is 1.009, that is, the proposed update is 0.9 percent.
- The proposed FY 2014 budget neutrality adjustment factor that is applied to the proposed capital Federal rate for proposed changes in the MS-DRG classifications and relative weights and proposed changes in the GAFs is 0.9988.
- The proposed FY 2014 outlier adjustment factor is 0.9451.

- A proposed adjustment factor of 0.9980 (that is, a reduction of 0.2 percent) to offset the estimated additional IPPS expenditures that are projected to result from our policy proposal on admission and medical review criteria for hospital inpatient services under Medicare Part A.

(We note, in section VI.D. of the preamble of this proposed rule, we discuss the MS-DRG documentation and coding adjustment, including our proposed -0.8 percent recoupment adjustment to the operating IPPS standardized amount in FY 2014 under the provisions of section 631 of the ATRA, as well as additional prospective adjustments for the MS-DRG documentation and coding effect through FY 2010 authorized under section 1886(d)(3)(A)(vi) of the Act. Although we are not proposing an additional prospective adjustment in FY 2014 for the cumulative MS-DRG documentation and coding effects through FY 2010, we are soliciting public comments as to whether any portion of the proposed -0.8 percent recoupment adjustment to the operating IPPS standardized amount should be reduced and instead applied as a prospective adjustment to the operating IPPS standardized amount (and hospital-specific rates) for the cumulative MS-DRG documentation and coding effect through FY 2010. We discuss in that same section that if we were to attribute a portion of the proposed -0.8 percent recoupment adjustment to the operating IPPS standardized amount for FY 2014 as a prospective adjustment, under the Secretary's broad authority under section 1886(g) of the Act, we also would make an appropriate adjustment to the national capital IPPS Federal rate (and note that the capital IPPS Puerto Rico rate would not be affected.)

Because the proposed capital Federal rate has already been adjusted for differences in case-mix, wages, cost-of-living, indirect medical education costs, and payments to hospitals serving a disproportionate share of low-income patients, we are not proposing to make additional adjustments in the capital Federal rate for these factors, other than the proposed budget neutrality factor for proposed changes in the MS-DRG classifications and relative weights and for proposed changes in the GAFs. (As noted previously in this section, there is no need for an exceptions payment adjustment budget neutrality factor in determining the FY 2014 capital Federal rate.)

We are providing the following chart that shows how each of the proposed factors and proposed adjustments for FY 2014 affects the computation of the proposed FY 2014