



Special Bulletin

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CMS IMPLEMENTS EXTENSION OF PAYMENT ADJUSTMENT FOR LOW-VOLUME AND MEDICARE-DEPENDENT HOSPITAL PROGRAMS

The Centers for Medicare & Medicaid Services (CMS) on Friday, March 14, issued an [interim final rule](#) implementing a six-month extension of both the low-volume payment adjustment and the Medicare-dependent Hospital (MDH) program, as required by legislation passed in December (the Pathway for SGR Reform Act of 2013). The interim final rule is applicable for discharges under the inpatient prospective payment system (PPS) on or after Oct. 1, 2013, and on or before March 31, 2014. CMS will accept comments on the interim final rule for a period of 60 days.

Details are provided below. However, it is critical to note that, to qualify for the extension of the low-volume adjustment, hospitals must notify/make requests to their Medicare Administrative Contractor (MAC) no later than March 31.

EXTENSION OF THE PAYMENT ADJUSTMENT FOR LOW-VOLUME HOSPITALS

The Affordable Care Act (ACA) provided for a temporary change to the low-volume hospital definition for fiscal years (FYs) 2011 and 2012, which was then extended by the American Taxpayer Relief Act of 2012 through Sept. 30, 2013. Under this change, a hospital qualified for the low-volume payment adjustment if it was located more than 15 road miles from another hospital (as defined by subsection (d) of the Social Security Act) and had fewer than 1,600 Medicare discharges during a fiscal year.

Section 1105 of the Pathway for SGR Reform Act of 2013 retroactively extended this enhanced low-volume hospital definition for an additional six months, to cover the period from Oct. 1, 2013 through March 31, 2014. After March 31, the definition will revert to the pre-ACA definition, and a hospital will qualify for the low-

volume payment adjustment only if it is located more than 25 miles from another subsection (d) hospital and has fewer than 200 total discharges during a fiscal year.

Consistent with the agency's historical policy, qualifying low-volume hospitals and their payment adjustment will be determined using Medicare discharge data from the March 2013 update of the FY 2012 Medicare Provider Analysis and Review (MedPAR) file. [Table 14](#) of the interim final rule lists those hospitals meeting the discharge criterion – the FY 2014 low-volume payment adjustment that would be available to those that also meet the mileage criterion. A hospital must notify and provide documentation to its MAC that it meets the mileage criterion – that it is located more than 15 road miles from another subsection (d) hospital. CMS specifies that the use of a web-based mapping tool, such as MapQuest, is acceptable as part of documenting that the hospital meets the mileage criterion.

A hospital must make its request for low-volume hospital status in writing to its MAC and this request must be received no later than March 31. A hospital that qualified for the low-volume payment adjustment in FY 2013 may continue to receive a low-volume payment adjustment for FY 2014 discharges occurring on or before March 31 without reapplying if it continues to meet the discharge and distance criterion; however, the hospital must send written verification that is received by its MAC no later than March 31 that it continues to be more than 15 miles from any other subsection (d) hospital.

EXTENSION OF THE MDH PROGRAM

The MDH program was extended by the American Taxpayer Relief Act of 2012 through Sept. 30, 2013. **Section 1106 of the Pathway for SGR Reform Act of 2013 extended the MDH program for an additional six months, to cover the period from Oct. 1, 2013 through March 31.** Beginning April 1, all hospitals that previously qualified for MDH status will no longer have MDH status.

CMS states, in general, that a hospital classified as an MDH as of the Sept. 30, 2013 expiration of the MDH program, will be reinstated as an MDH, effective Oct. 1, 2013 through March 31, with no need to reapply for the MDH classification. There are two situations, however, in which MDH status may not be retroactive to Oct. 1, 2013:

1. **MDHs classified as Sole Community Hospitals (SCHs) on or after Oct. 1, 2013.** In anticipation of the expiration of the MDH program, many MDHs applied for, and were granted, SCH status. Hospitals cannot be classified as both a MDH and a SCH – therefore, those MDH hospitals now classified as SCHs will not be

able to qualify for MDH status retroactive to Oct. 1, 2013, but may be able to for a portion of the time, if the hospital was classified as a MDH during the Oct. 1, 2013 through March 31, 2014 period. These hospitals may apply for MDH status prospectively by cancelling their SCH status and reapplying for MDH status, but it is unlikely this process will be completed prior to the March 31 expiration of the MDH program and it is unclear how hospitals that do so will be classified after the March 31 expiration of the MDH program.

- 2. MDHs that requested cancellation of their rural classification.** In order to be classified as a MDH, a hospital must be located in a rural area. To qualify for MDH status, some MDHs reclassified from an urban to a rural hospital designation – some of those MDHs may have requested a cancellation of their rural classification in anticipation of the Sept. 30, 2013 expiration of the MDH program. These hospitals will not be able to qualify for MDH status retroactive to Oct. 1, 2013, but may be able to for a portion of the time, if the hospital maintained its rural classification during the Oct. 1, 2013 through March 31, 2014 period. Hospitals may be reclassified as rural and reapply for MDH status prospectively, but it is unlikely this process will be completed prior to the March 31 expiration of the MDH program and it is unclear how hospitals that do so will be classified after the March 31 expiration of the MDH program.

In the interim final rule, CMS provides examples of various scenarios to illustrate how and when MDH status will be determined for hospitals that were MDHs as of the Sept. 30, 2013 expiration of the MDH program, including those that may have reclassified as SCHs or cancelled their rural classification. The agency indicated it will release further program guidance, but did not say when, on the systems implementation of these provisions. Providers affected by the MDH program extension will receive notifications from their MAC detailing their status.

Lastly, CMS addresses how Medicare disproportionate share hospital (DSH) uncompensated care payments, mandated by the ACA, will be made to MDHs during this extension. MDHs are paid based on the federal rate or, if higher, the federal rate plus 75 percent of the amount by which the federal rate is exceeded by the updated hospital-specific cost. In determining MDH payments for discharges occurring on or from Oct. 1, 2013 through March 31, a pro rata share of the uncompensated care payment amount for that period will be included as part of the federal rate payment in the comparison of payments under the hospital-specific rate and the federal rate. This is consistent with the policy CMS established for SCHs.

The AHA is pleased CMS has issued this guidance. The AHA continues to work with Congress to extend these provisions, plus several others, past March 31, 2014 as part of any legislative package to fix the Medicare physician payment formula.

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