EXHIBIT B

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Department of Health and Human Services

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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 Fiscal Year 2014 Rates; Quality Reporting Requirements for Specific Providers; Hospital Conditions of Participation; Payment Policies Related to Patient Status; Final Rule

Response: We acknowledge that it is very important that clear and consistent instructions are provided to facilities, physicians, and Medicare review contractors. We intend to quickly develop implementation instructions, manual guidance, and additional education to ensure that all entities receive initial and ongoing guidance in order to promote consistent application of these changes and repeatable and reproducible decisions on individual cases. We intend to ensure that our instructions to providers and reviewers alike emphasize that the decision to admit should be based on and evaluated in respect to the information available to the admitting practitioner at the time of the admission.

After consideration of the public comments we received, we are including in this final rule several revisions and clarifications to the proposed policy. First, we are finalizing at § 412.3(e)(1) the 2-midnight benchmark as proposed at § 412.3(c)(1), that services designated by the OPPS Inpatient-Only list as inpatient-only would continue to be appropriate for inpatient hospital admission and payment under Medicare Part A. In addition, surgical procedures, diagnostic tests, and other treatments would be generally deemed appropriate for inpatient hospital admission and payment under Medicare Part A when the physician expects the patient to require a stay that crosses at least 2 midnights and admits the patient to the hospital based upon that expectation. We proposed at § 412.3(c)(2), and are finalizing at § 412.3(e)(2), that if an unforeseen circumstance, such as beneficiary death or transfer, results in a shorter beneficiary stay than the physician's expectation of at least 2 midnights, the patient may still be considered to be appropriately treated on an inpatient basis, and the hospital inpatient payment may be made under Medicare Part A. We proposed, and are now finalizing, two distinct, although related, medical review policies, a 2-midnight *benchmark* and a 2-midnight *presumption.* The 2-midnight benchmark represents guidance to admitting practitioners and reviewers to identify when an inpatient admission is generally appropriate for Medicare coverage and payment, while the 2-midnight presumption directs medical reviewers to select claims for review under a presumption that the occurrence of 2 midnights after admission appropriately signifies an inpatient status for a medically necessary claim. The starting point for the 2-midnight benchmark will be when the beneficiary begins receiving hospital care on either an inpatient basis or outpatient basis. That is, for purposes of determining whether the 2-midnight benchmark will be met and, therefore, whether inpatient admission is generally appropriate, the physician ordering the admission should account for time the beneficiary spent receiving outpatient services such as observation services, treatments in the emergency department, and procedures provided in the operating room or other treatment area. From the medical review perspective, while the time the beneficiary spent as an outpatient before the admission order is written will not be considered inpatient time, it may be considered during the medical review process for purposes of determining whether the 2-midnight benchmark was met and, therefore, whether payment is generally appropriate under Part A. For beneficiaries who do not arrive through the emergency department or are directly receiving inpatient services (for example, inpatient admission order written prior to admission for an elective admission or transfer from another hospital), the starting point for medical review purposes will be when the beneficiary starts receiving services following arrival at the hospital. We proposed that both the decision to keep the patient at the hospital and the expectation of needed duration of the stay would be based on such factors as beneficiary medical history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event. In this final rule, we now are clarifying that risk (or probability) of an adverse event relates to occurrences during the time period for which hospitalization is considered.

We are finalizing that inpatient hospital claims with lengths of stay greater than 2 midnights after the formal admission following the order will be presumed generally appropriate for Part A payment and will not be the focus of medical review efforts absent evidence of systematic gaming, abuse, or delays in the provision of care in an attempt to qualify for the 2-midnight presumption. We also are clarifying in this final rule how we will instruct contractors to review inpatient stays spanning less than 2 midnights after admission. Such claims would not be subject to the presumption that services were appropriately provided during an inpatient stay rather than an outpatient stay because the total inpatient time did not exceed 2 midnights. However, upon medical review, the time spent as an outpatient will be counted toward meeting the 2-midnight benchmark that the physician is expected to apply to determine the appropriateness of the decision to admit. In other words, even though the inpatient admission was for only 1 Medicare utilization day, medical reviewers will consider the fact that the beneficiary was in the hospital for greater than 2 midnights following the onset of care when making the determination of whether the inpatient stay was reasonable and necessary. For those admissions in which the basis for the physician expectation of care surpassing 2 midnights is reasonable and well-documented, reviewers may apply the 2-midnight benchmark to incorporate all time receiving care in the hospital. We will continue to use our existing monitoring and audit authority, such as the CERT program, to ensure that our review efforts focus on those subsets of claims with the highest error rates and reduce the administrative burden for those subsets that have demonstrated compliance with our clarified and modified guidance.

4. Impacts of Changes in Admission and Medical Review Criteria

In the FY 2014 IPPS/LTCH PPS proposed rule (78 FR 27649 through 27650), we discussed our actuaries' estimate that our proposed 2-midnight policy (referred to in this final rule as the 2-midnight benchmark and the 2-midnight presumption) 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 OPPS, and some encounters of less than 2 midnights moving from the IPPS to the OPPS. 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. Because 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 2-midnight policy on the IPPS and the systemic nature of the issue of inpatient status and improper payments under Medicare Part A for short-stay inpatient hospital claims, we stated our belief that it is appropriate to use our exceptions and adjustments authority under section 1886(d)(5)(I)(i) of the Act to propose to offset the estimated $220 million in additional IPPS expenditures associated with the 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 proposed to reduce the standardized amount, the hospital-specific rates, and the Puerto Rico-specific standardized amount by 0.2 percent.

Comment: Commenters generally did not support the proposed -0.2 percent payment adjustment. Comments included the following assertions: CMS actuaries' estimated increase in IPPS expenditures of $220 million was unsupported and insufficiently explained to allow for meaningful comment; CMS did not provide sufficient rationale for the use of our exceptions and adjustments authority under section 1886(d)(5)(I)(i) of the Act; CMS should not be adjusting the IPPS payment rates for expected shifts in utilization between inpatient and outpatient; CMS did not take into account the impact of the Part B Inpatient Billing proposed rule in developing its estimates; CMS should provide parallel treatment regarding the financial impact of both the medical review policy in the FY 2014 IPPS/LTCH PPS proposed rule and the policies in the Part B Inpatient Billing proposed rule and offset and restore the $4.8 billion dollar reduction to hospital payments over 5 years contained in the Part B Inpatient Billing proposed rule; and CMS' proposed policy was a coverage decision and CMS should not adjust IPPS rates for coverage decisions.

Response: We disagree with commenters who indicated that our actuaries' estimated increase in IPPS expenditures of $220 million was unsupported and insufficiently explained to allow for meaningful comment. In the FY 2014 IPPS/LTCH PPS proposed rule (78 FR 27649), we specifically discussed the methodology used and the components of the estimate. Our actuaries examined FY 2009 to FY 2011 claims data. Based on this examination, we stated the number of encounters our actuaries estimated would shift from inpatient to outpatient (360,000) and the number of encounters they estimated would shift from outpatient to inpatient (400,000). We described the methodology we used to translate this net shift of 40,000 encounters into our $220 million estimate, including an estimate of the increase these 40,000 encounters represent in shorter stay hospital inpatient encounters (1.2 percent), the share that expenditures for shorter stay hospital inpatient encounters represent of IPPS expenditures (17 percent), and our estimate of the payment difference between OPPS and IPPS for these encounters (OPPS payment for these encounters was estimated to be 30 percent of the IPPS payment for these encounters). In addition to the opportunity to comment on the estimate, any component of the estimate, or the methodology, commenters had an opportunity to provide alternative estimates for us to consider.

In determining the estimate of the number of encounters that would shift from outpatient to inpatient, our actuaries examined outpatient claims for observation or a major procedure. Claims not containing observation or a major procedure were excluded. The number of claims spanning 2 or more midnights based on the dates of service that were expected to become inpatient was approximately 400,000. This estimate did not include any assumption about outpatient encounters shorter than 2 midnights potentially becoming inpatient encounters.

In determining the estimate of the number of encounters that would shift from inpatient to outpatient, our actuaries examined inpatient claims containing a surgical MS–DRG. Claims containing medical MS–DRGs were excluded. The number of claims spanning less than 2 midnights based on the length of stay that were expected to become outpatient, after excluding encounters that resulted in death or transfers, was approximately 360,000.

The estimates of the shifts in encounters as described above were primarily based on FY 2011 Medicare inpatient and outpatient claims data. However, our actuaries also examined FY 2009 and FY 2010 Medicare inpatient and outpatient claims data and found the results for the earlier years were consistent with the FY 2011 results.

While there is a certain degree of uncertainty surrounding any cost estimate, our actuaries have determined that the methodology, data, and assumptions used are reasonable for the purpose of estimating the overall impact of our proposed policy. We note that the assumptions used for purposes of reasonably estimating the overall impact in FY 2014 should not be construed as absolute statements about every individual encounter. For example, we fully expect that not every single surgical MS–DRG encounter spanning less than 2 midnights will shift to outpatient and that not every single outpatient observation stay or major surgical encounter spanning more than 2 midnights will shift to inpatient.

We also disagree with commenters who indicated that we did not provide sufficient rationale for the use of our exceptions and adjustments authority under section 1886(d)(5)(I)(i) of the Act. We discussed that the issue of patient status has a substantial impact on improper payments under Medicare Part A for short-stay inpatient hospital claims, citing the fact that the majority of improper payments under Medicare Part A for short-stay inpatient hospital claims have been due to inappropriate patient status. In 2012, for example, 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 decreased significantly for 2-day or 3-day stays, which had improper payment rates of 13.2 percent and 13.1 percent, respectively. We stated that we believed the magnitude of these national figures demonstrates that issues surrounding the appropriate determination of a beneficiary's patient status are not isolated to a few hospitals. We also noted that the RAs had recovered more than $1.6 billion in improper payments because of inappropriate beneficiary patient status. While we agree with commenters that our exceptions and adjustments authority should not be routinely used in the IPPS system, we believe that the systemic and widespread nature of this issue justifies an overall adjustment to the IPPS rates and such an adjustment is authorized under section 1886(d)(5)(I)(i) of the Act.

For similar reasons, while we generally agree with commenters that it is not necessary to routinely estimate utilization shifts to ensure appropriate IPPS payments, this is a unique situation. Policy clarifications such as

this do not usually result in utilization shifts of sufficient magnitude and breadth to significantly impact the IPPS. In this situation, we believe it would be inappropriate to ignore such a utilization shift in the development of the IPPS payment rates.

With respect to the comments that we did not take into account the impact of the Part B Inpatient Billing proposed rule in developing our estimates, we note that our actuaries did take those impacts into account in developing our proposed adjustment. Our estimate of the net shift in FY 2014 encounters between inpatient and outpatient would have been substantially higher in the absence of the policies discussed in the Part B Inpatient Billing proposed rule, in particular the discussion of timely filing. Specifically, in the absence of the timely filing requirement, there would be fewer inpatient encounters estimated to become outpatient encounters, which would have resulted in a larger cost than our estimated $220 million.

With respect to the comment that CMS should provide parallel treatment regarding the financial impact of the medical review policy in the FY 2014 IPPS/LTCH PPS proposed rule and the interrelated Part B Inpatient Billing proposed rule by offsetting and restoring the estimated $4.8 billion dollar reduction to hospital payments contained in that rule, we note that, although we estimated a decrease in expenditures as a result of our proposed Part B inpatient billing policy, this decrease in expenditures is offset by the costs of the significant number of related administrative appeal decisions as well as CMS Ruling 1455–R, which allows hospitals to seek payment of Part B inpatient services on claims filed outside the timely filing period. As discussed in greater detail in the Regulatory Impact Analysis in the Part B Inpatient Billing proposed rule (78 FR 16643), the combined impact of the appeals decisions, CMS Ruling 1455–R, and Part B inpatient billing policy, to which the 12-month timely filing requirement applies, is an estimated cost to the Medicare program of $1.03 billion over the CY 2013 to CY 2017 time period. We estimate in the Regulatory Impact Analysis of the final Part B inpatient payment policy in this final rule that the combined impact of the appeals decisions, CMS Ruling 1455–R, and the Part B inpatient billing policy will cost the Medicare program $1.260 billion over the CY 2013 to CY 2017 time period.

Finally, we disagree with those comments asserting that the modification and clarification of our current instructions regarding the circumstances under which Medicare will generally pay for a hospital inpatient admission in order to improve hospitals' ability to make appropriate admission decisions are actually coverage decisions in the context of this adjustment. As we clearly stated in the FY 2014 IPPS/LTCH PPS proposed rule (78 FR 27648), we will continue to review individual claims to ensure the hospital services furnished to beneficiaries are ''reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member,'' as required by section 1862(a)(1) of the Act. Any hospital service determined to be not reasonable or necessary may not be paid under Medicare Part A or Part B. In the context of this adjustment, these are not new hospital services.

Our actuaries continue to estimate there will be approximately $220 million in additional expenditures resulting from our 2-midnight benchmark and 2-midnight presumption medical review policies. This net increase in hospital inpatient encounters is 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. Therefore, after consideration of the comments we received, and for the reasons described above, we are finalizing a reduction to the standardized amount, the hospital-specific rates, and the Puerto Rico-specific standardized amount of −0.2 percent to offset the additional $220 million in expenditures.

XII. MedPAC Recommendations

Under section 1886(e)(4)(B) of the Act, the Secretary must consider MedPAC's recommendations regarding hospital inpatient payments. Under section 1886(e)(5) of the Act, the Secretary must publish in the annual proposed and final IPPS rules the Secretary's recommendations regarding MedPAC's recommendations. We have reviewed MedPAC's March 2013 ''Report to the Congress: Medicare Payment Policy'' and have given the recommendations in the report consideration in conjunction with the policies set forth in this final rule. MedPAC recommendations for the IPPS for FY 2014 are addressed in Appendix B to this final rule.

For further information relating specifically to the MedPAC reports or to obtain a copy of the reports, contact MedPAC at (202) 653–7226, or visit MedPAC's Web site at: *http://www.medpac.gov*.

XIII. Other Required Information

A. Requests for Data From the Public

In order to respond promptly to public requests for data related to the prospective payment system, we have established a process under which commenters can gain access to raw data on an expedited basis. Generally, the data are now available on compact disc (CD) format. However, many of the files are available on the Internet at: *http://www.cms.hhs.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html*. We listed the data files and the cost for each file, if applicable, in the FY 2014 IPPS/LTCH PPS proposed rule (78 FR 27746 through 27748).

Commenters interested in discussing any data used in constructing the proposed rule or this final rule should contact should contact Nisha Bhat at (410) 786–5320.

B. Collection of Information Requirements

1. Statutory Requirement for Solicitation of Comments

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

In the FY 2014 IPPS/LTCH PPS proposed rule (78 FR 27748 through 27755), we solicited public comment on each of these issues for the following sections of this document that contain information collection requirements (ICRs). We discuss and respond to any public comments we received in the relevant sections.

2. ICRs for Add-On Payments for New Services and Technologies

Section II.I.1. of the preamble of the proposed rule and this final rule discusses add-on payments for new

Response: We thank the commenter for bringing this issue to our attention. In the proposed rule, we inadvertently used CCRs from FY 2011 in our estimate of the FY 2012 outlier payments. For this final rule, we corrected this error and determined an estimated FY 2012 outlier payment that is nearly identical to the commenters. We believe the refinements made to the calculation of the FY 2014 outlier threshold will help ensure that outlier payments meet the 5.1 percent target.

5. FY 2014 Standardized Amount

The adjusted standardized amount is divided into labor-related and nonlabor-related portions. Tables 1A and 1B listed and published in section VI. of this Addendum (and available via the Internet) contain the national standardized amounts that we are applying to all hospitals, except hospitals located in Puerto Rico, for FY 2014. The Puerto Rico-specific amounts are shown in Table 1C listed and published in section VI. of this Addendum (and available via the Internet). The amounts shown in Tables 1A and 1B differ only in that the labor-related share applied to the standardized amounts in Table 1A is the labor-related share of 69.6 percent, and Table 1B is 62 percent. In accordance with sections 1886(d)(3)(E) and 1886(d)(9)(C)(iv) of the Act, we are applying a labor-related share of 62 percent, unless application of that percentage would result in lower payments to a hospital than would otherwise be made. In effect, the statutory provision means that we will apply a labor-related share of 62 percent for all hospitals whose wage indices are less than or equal to 1.0000.

In addition, Tables 1A and 1B include the standardized amounts reflecting the applicable percentage increase of 1.7 percent for FY 2014, and an update of −0.3 percent for hospitals that fail to submit quality data consistent with section 1886(b)(3)(B)(viii) of the Act.

Under section 1886(d)(9)(A)(ii) of the Act, the Federal portion of the Puerto Rico payment rate is based on the discharge-weighted average of the national large urban standardized amount (this amount is set forth in Table 1A). The labor-related and nonlabor-related portions of the national average standardized amounts for Puerto Rico hospitals for FY 2014 are set forth in Table 1C listed and published in section VI. of this Addendum (and available via the Internet). This table also includes the Puerto Rico standardized amounts. The labor-related share applied to the Puerto Rico-specific standardized amount is the labor-related share of 63.2 percent, or 62 percent, depending on which provides higher payments to the hospital. (Section 1886(d)(9)(C)(iv) of the Act, as amended by section 403(b) of Public Law 108–173, provides that the labor-related share for hospitals located in Puerto Rico be 62 percent, unless the application of that percentage would result in lower payments to the hospital.)

The following table illustrates the changes from the FY 2013 national standardized amount. The second column shows the changes from the FY 2013 standardized amounts for hospitals that satisfy the quality data submission requirement and, therefore, receive the full update of 1.7 percent. The third column shows the changes for hospitals receiving the reduced update of −0.3 percent. The first row of the table shows the updated (through FY 2013) average standardized amount after restoring the FY 2013 offsets for outlier payments, demonstration budget neutrality, the geographic reclassification budget neutrality, and the retrospective documentation and coding adjustment under section 7(b)(1)(B) of Public Law 110–90. The MS–DRG reclassification and recalibration wage index budget neutrality factors are cumulative. Therefore, those FY 2013 factors are not removed from this table.

COMPARISON OF FY 2013 STANDARDIZED AMOUNTS TO THE FY 2014 STANDARDIZED AMOUNT WITH FULL AND REDUCED UPDATE

	Full update (1.7 percent); wage index is greater than 1.0000; labor/non-labor share percentage (69.6/30.4)	Full update (1.7 percent); wage index is less than or equal to 1.0000; labor/non-labor share percentage (62/38)	Reduced update (−0.3 percent); wage index is greater than 1.0000; labor/non-labor share percentage (69.6/30.4)	Reduced update (−0.3 percent); wage index is less than or equal to 1.0000; labor/non-labor share percentage (62/38)
FY 2013 Base Rate after removing: 1. FY 2013 Geographic Reclassification Budget Neutrality (0.991276). 2. FY 2013 Rural Community Hospital Demonstration Program Budget Neutrality (0.999677). 3. Cumulative FY 2008, FY 2009, FY 2012, FY 2013 Documentation and Coding Adjustment as Required under Sections 7(b)(1)(A) and 7(b)(1)(B) of Public Law 110–90 (0.9478). 4. FY 2013 Operating Outlier Offset (0.948999).	Labor: $4,176.63 ..... Nonlabor: $1,824.27 ...	Labor: $3,720.56 ..... Nonlabor: $2,280.34 ...	Labor: $4,176.63 ..... Nonlabor: $1,824.27 ...	Labor: $3,720.56 Nonlabor: $2,280.34
FY 2014 Update Factor	1.017	1.017	0.997	0.997
FY 2014 MS–DRG Recalibration and Wage Index Budget Neutrality Factor.	0.997936	0.997936	0.997936	0.997936
FY 2014 Reclassification Budget Neutrality Factor.	0.990718	0.990718	0.990718	0.990718
FY 2014 Rural Community Demonstration Program Budget Neutrality Factor.	0.999415	0.999415	0.999415	0.999415
FY 2014 Operating Outlier Factor	0.948995	0.948995	0.948995	0.948995
Adjustment to Offset the Cost of the Policy on Admission and Medical Review Criteria for Hospital Inpatient Services under Medicare Part A.	0.998	0.998	0.998	0.998

COMPARISON OF FY 2013 STANDARDIZED AMOUNTS TO THE FY 2014 STANDARDIZED AMOUNT WITH FULL AND REDUCED UPDATE—Continued

	Full update (1.7 percent); wage index is greater than 1.0000; labor/non-labor share percentage (69.6/30.4)	Full update (1.7 percent); wage index is less than or equal to 1.0000; labor/non-labor share percentage (62/38)	Reduced update (−0.3 percent); wage index is greater than 1.0000; labor/non-labor share percentage (69.6/30.4)	Reduced update (−0.3 percent); wage index is less than or equal to 1.0000; labor/non-labor share percentage (62/38)
Cumulative Factor: FY 2008, FY 2009, FY 2012, and FY 2013 Documentation and Coding Adjustment as Required under Sections 7(b)(1)(A) and 7(b)(1)(B) of Public Law 110–90 and Documentation and Coding Recoupment Adjustment as required under Section 631 of the American Taxpayer Relief Act of 2012.	0.9403	0.9403	0.9403	0.9403
Final National Standardized Amount for FY 2014.	Labor: $3,737.71 Nonlabor: $1,632.57	Labor: $3,329.57 Nonlabor: $2,040.71	Labor: $3,664.21 Nonlabor: $1,600.46	Labor: $3,264.10 Nonlabor: $2,000.57

The following table illustrates the changes from the FY 2013 Puerto Rico-specific payment rate for hospitals located in Puerto Rico. The second column shows the changes from the FY 2013 Puerto Rico specific payment rate for hospitals with a Puerto Rico-specific wage index greater than 1.0000. The third column shows the changes from the FY 2013 Puerto Rico specific payment rate for hospitals with a Puerto Rico-specific wage index less than 1.0000. The first row of the table shows the updated (through FY 2013) Puerto Rico-specific payment rate after restoring the FY 2013 offsets for Puerto Rico-specific outlier payments, rural community hospital demonstration program budget neutrality, and the geographic reclassification budget neutrality. The MS–DRG recalibration budget neutrality factor is cumulative and is not removed from this table.

COMPARISON OF FY 2013 PUERTO RICO-SPECIFIC PAYMENT RATE TO THE FY 2014 PUERTO RICO-SPECIFIC PAYMENT RATE

	Update (1.7 percent); wage index is greater than 1.0000; labor/non-labor share percentage (63.2/36.8)	Update (1.7 percent); wage index is less than or equal to 1.0000; labor/non-labor share percentage (62/38)
FY 2013 Puerto Rico Base Rate, after removing: 1. FY 2013 Geographic Reclassification Budget Neutrality (0.991276) 2. FY 2013 Rural Community Hospital Demonstration Program Budget Neutrality (0.999677).		
3. FY 2013 Puerto Rico Operating Outlier Offset (0.944760)	Labor: $1,700.33 Nonlabor: $990.07	Labor: $1,668.05 Nonlabor: $1,022.35
FY 2014 Update Factor	1.017	1.017
FY 2014 MS–DRG Recalibration Budget Neutrality Factor	0.997989	0.997989
FY 2014 Reclassification Budget Neutrality Factor	0.990718	0.990718
FY 2014 Rural Community Hospital Demonstration Program Budget Neutrality Factor.	0.999415	0.999415
FY 2014 Puerto Rico Operating Outlier Factor	0.943455	0.943455
Adjustment to Offset the Cost of the Policy on Admission and Medical Review Criteria for Hospital Inpatient Services under Medicare Part A.	0.998	0.998
Final Puerto Rico–Specific Payment Rate for FY 2014	Labor: $1,608.90 Nonlabor: $936.82	Labor: $1,578.35 Nonlabor: $967.37

B. Adjustments for Area Wage Levels and Cost-of-Living

Tables 1A through 1C, as published in section VI. of this Addendum (and available via the Internet), contain the labor-related and nonlabor-related shares that we used to calculate the prospective payment rates for hospitals located in the 50 States, the District of Columbia, and Puerto Rico for FY 2014. This section addresses two types of adjustments to the standardized amounts that are made in determining the prospective payment rates as described in this Addendum.

1. Adjustment for Area Wage Levels

Sections 1886(d)(3)(E) and 1886(d)(9)(C)(iv) of the Act require that we make an adjustment to the labor-related portion of the national and Puerto Rico prospective payment rates, respectively, to account for area differences in hospital wage levels. This adjustment is made by multiplying the labor-related portion of the adjusted standardized amounts by the appropriate wage index for the area in which the hospital is located. In section III. of the preamble of this final rule, we discuss the data and methodology for the FY 2014 wage index.

2. Adjustment for Cost-of-Living in Alaska and Hawaii

Section 1886(d)(5)(H) of the Act provides discretionary authority to the Secretary to make ''such adjustments . . . as the Secretary deems appropriate to take into account the unique circumstances of hospitals located in Alaska and Hawaii.'' Higher labor-related costs for these two States are taken into account in the adjustment for area wages described above. To account for higher nonlabor-related costs for these two States, we multiply the nonlabor-related portion of the standardized amount for hospitals located in Alaska and Hawaii by an

adjustment factor. For FY 2011 and in prior fiscal years, we used the most recent cost-of-living adjustment (COLA) factors obtained from the U.S. Office of Personnel Management (OPM) Web site at: *http://www.opm.gov/oca/cola/rates/asp* to update this nonlabor portion.

In the FY 2013 IPPS/LTCH PPS proposed and final rules (77 FR 28145 through 28146 and 77 FR 53700 through 53701, respectively), we explained that statutory changes transitioned the Alaska and Hawaii COLAs to locality pay. We further explained that, beginning in FY 2012, as OPM transitioned away from COLAs, we continued to use the same ''frozen'' COLA factors that were used to adjust payments in FY 2011 (based on OPM's 2009 COLA factors) to adjust the nonlabor-related portion of the standardized amount for hospitals located in Alaska and Hawaii while we explored alternatives for updating the COLA factors in the future. In the FY 2013 IPPS/LTCH PPS final rule, for FY 2013, we continued to use the same COLA factors used to adjust payments in FY 2012 (which are based on OPM's 2009 COLA factors). We also established a methodology to update the COLA factors for Alaska and Hawaii that were published by OPM every 4 years (at the same time as the update to the labor-related share of the IPPS market basket), beginning in FY 2014. We refer readers to the FY 2013 IPPS/LTCH PPS proposed and final rules for additional background and a detailed description of this methodology (77 FR 28145 through 28146 and 77 FR 53700 through 53701, respectively).

For FY 2014, we proposed to update the COLA factors published by OPM for 2009 (as these are the last COLA factors OPM published prior to transitioning from COLAs to locality pay) using the methodology that we finalized in the FY 2013 IPPS/LTCH PPS final rule. Under our proposal, we proposed COLA factors for FY 2014 for the three specified urban areas of Alaska (Anchorage, Fairbanks and Juneau) of 1.23; for the City and County of Honolulu, the County of Kauai, the County of Maui, the County of Kalawao, and ''All other'' areas of Alaska of 1.25; and for the County of Hawaii of 1.19. For additional details on our proposal, we refer readers to the FY 2014 IPPS/LTCH PPS proposed rule (77 FR 27770 through 27771). We did not receive any public comments on our proposed COLA factors for FY 2014 and, therefore, are adopting them as final in this final rule without modification. The development of the COLA factors for FY 2014 is described below.

For FY 2014, we are updating the COLA factors for Alaska and Hawaii published by OPM for 2009 (as these are the last COLA factors OPM published prior to transitioning from COLAs to locality pay) using the methodology that we finalized in the FY 2013 IPPS/LTCH PPS final rule. Specifically, under our methodology, we are using a comparison of the growth in the Consumer Price Indices (CPIs) in Anchorage and Honolulu relative to the growth in the overall CPI as published by the Bureau of Labor Statistics (BLS) to update the COLA adjustment factors for all areas in Alaska and Hawaii, respectively. As discussed in the FY 2013 IPPS/LTCH PPS proposed rule (77 FR 28145 through 28146), because BLS publishes CPI data for only Anchorage, Alaska and Honolulu, Hawaii, our methodology for updating the COLA factors uses a comparison of the growth in the CPIs for those cities relative to the growth in the overall CPI to update the COLA adjustment factors for all areas in Alaska and Hawaii, respectively. We believe that the relative price differences between these cities and the United States (as measured by the CPIs mentioned above) are generally appropriate proxies for the relative price differences between the ''other areas'' of Alaska and Hawaii and the United States.

The CPIs for ''All Items'' that BLS publishes for Anchorage, Alaska, Honolulu, Hawaii, and for the average U.S. city are based on a different mix of commodities and services than is reflected in the nonlabor-related share of the IPPS market basket. As such, under the methodology we established to update the COLA factors, we calculated a ''reweighted CPI'' using the CPI for commodities and the CPI for services for each of the geographic areas to mirror the composition of the IPPS market basket nonlabor-related share. The current composition of BLS' CPI for ''All Items'' for all of the respective areas is approximately 40 percent commodities and 60 percent services. However, the nonlabor-related share of the IPPS market basket is comprised of approximately 60 percent commodities and 40 percent services. Therefore, under the methodology we established in the FY 2013 IPPS/LTCH PPS final rule, we have created reweighted indexes for Anchorage, Alaska, Honolulu, Hawaii, and the average U.S. city using the respective CPI commodities index and CPI services index and applying the approximate 60/40 weights from the IPPS market basket. We believe that this methodology is appropriate because we would continue to make a COLA adjustment for hospitals located in Alaska and Hawaii by multiplying the nonlabor-related portion of the standardized amount by a COLA factor.

Under the COLA factor update methodology we established in the FY 2013 IPPS/LTCH PPS final rule, we further exercised our discretionary authority to adjust payments made to hospitals located in Alaska and Hawaii by incorporating a 25-percent cap on the CPI-updated COLA factors used to adjust the nonlabor-related portion of the standardized amounts, which is consistent with a statutorily mandated 25-percent cap that was applied to OPM's published COLA factors. We believe that this is appropriate because our CPI-updated COLA factors for FY 2014 use the 2009 OPM COLA factors as a basis. In addition, we are continuing to establish COLA factors that are rounded to 2 decimal places, which is consistent with the number of decimal places in the 2009 OPM COLA factors that are used as the basis for calculating the FY 2014 COLA factors. This policy also will maintain consistency with the rounding used for the 25-percent cap on the COLA factors (that is, a COLA factor of no more than 1.25).

Applying this methodology, we are establishing the COLA factors for FY 2014 that will adjust the nonlabor-related portion of the standardized amount for hospitals located in Alaska and Hawaii as shown in the table below.

FY 2014 COST-OF-LIVING ADJUSTMENT FACTORS: ALASKA AND HAWAII HOSPITALS

Area	Cost of living adjustment factor
Alaska:	
City of Anchorage and 80-kilometer (50-mile) radius by road	1.23
City of Fairbanks and 80-kilometer (50-mile) radius by road	1.23
City of Juneau and 80-kilometer (50-mile) radius by road	1.23
Rest of Alaska	1.25
Hawaii:	
City and County of Honolulu	1.25
County of Hawaii	1.19
County of Kauai	1.25
County of Maui and County of Kalawao	1.25

Each of the COLA factors was calculated using data through 2012 as these are the latest historical CPI data published by the BLS. The reweighted CPI for Honolulu, Hawaii grew faster than the reweighted CPI for the average U.S. city over the time period from 2009 to 2012, with a growth rate of 8.9 percent and 8.3 percent, respectively. As a result, for FY 2014, we calculated COLA factors for the City and County of Honolulu, the County of Kauai, the County of Maui, and the County of Kalawao to be 1.26 compared to the FY 2013 COLA factor of 1.25. However, as stated above, our COLA factor update methodology caps COLA factors at

1.25. In addition, the COLA factor calculated for the County of Hawaii for FY 2014 is 1.19 compared to the FY 2013 COLA factor of 1.18.

The reweighted CPI for Anchorage, Alaska grew slower than the reweighted CPI for the average U.S. city over the time period from 2009 to 2012, with a growth rate of 8.0 percent and 8.3 percent, respectively. However, applying this slower relative growth rate to the FY 2009 COLA factors for each of the Alaska areas results in no change to the COLA factors for the Alaska areas for FY 2014 (1.25 for ''All other'' areas of Alaska and 1.23 for the three specified urban areas of Alaska (Anchorage, Fairbanks and Juneau)) as compared to the FY 2013 COLA factors.

C. Calculation of the Prospective Payment Rates

General Formula for Calculation of the Prospective Payment Rates for FY 2014

In general, the operating prospective payment rate for all hospitals paid under the IPPS located outside of Puerto Rico, except SCHs, for FY 2014 equals the Federal rate (which includes uncompensated care payments). (As noted above, due to the expiration of the MDH program, beginning with FY 2014, we are not including MDHs in our discussion of the update of the hospital-specific rates for FY 2014.)

SCHs are paid based on whichever of the following rates yields the greatest aggregate payment: The Federal national rate (which, as finalized in section V.E.3. of the preamble of this final rule, includes uncompensated care payments); 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 final rule. 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. Finally, we add the uncompensated care payment to the total claim payment amount. We note that, as finalized above, we take uncompensated care payments into consideration when calculating outlier payments.

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

a. Calculation of Hospital-Specific Rate

Section 1886(b)(3)(C) of the Act provides that SCHs are paid based on whichever of the following rates yields the greatest aggregate payment: The Federal rate (which, as finalized in section V.E.3. of the preamble of this final rule, includes uncompensated care payments); 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). We also refer readers to section V.E. of the preamble of this final rule for a complete discussion on DSH and uncompensated care payments.

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 applicable percentage increase to the hospital-specific rates applicable to SCHs is 1.7 percent (that is, the FY 2014 estimate of the market basket rate-of-increase of 2.5 percent less an adjustment of 0.5 percentage point for MFP and less 0.3 percentage point) for hospitals that submit quality data or −0.3 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 an adjustment of 0.5 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 final 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 MS–DRG reclassification and recalibration budget neutrality factor of 0.997989, 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 final rule, for FY 2014, we are not making a documentation and coding adjustment to the hospital-specific rate. We refer readers to section II.D. of the preamble of this final rule for a complete discussion regarding our finalized policies 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 final rule also includes a discussion on documentation and coding effects that occurred through FY 2010, including the request for public comments in the FY 2014 IPPS/LTCH PPS proposed rule as to whether any portion of the −0.8 percent recoupment adjustment discussed in section II.D.6. of the preamble of this final rule should be reduced and instead applied as a prospective adjustment for the cumulative MS–DRG documentation and coding effect through FY 2010.

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

As discussed previously, in section XI.C. of the preamble of this final rule, our actuaries project additional IPPS expenditures will result from our 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 after inpatient admission (which is presented in section XI.C. of the preamble of this final rule). We believe that it is appropriate to use our exceptions and adjustments authority under section 1886(d)(5)(I)(i) of the Act to apply reductions

of 0.2 percent (or a 0.998 adjustment) to the IPPS rates, including the FY 2014 hospital-specific rate for SCHs, to offset our estimate of the increase in IPPS payments. We refer readers to section XI.C. of the preamble of this final rule for a complete discussion of our policy 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.

Finally, we add the uncompensated care payment to the total claim payment amount. We note that, as finalized above, we take uncompensated care payments into consideration when calculating outlier payments.

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

As discussed previously, in section XI.C. of the preamble of this final rule, our actuaries project additional IPPS expenditures will result from our 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 after inpatient admission (which is presented in section XI.C. of the preamble of this final rule). We believe that it is appropriate to use our exceptions and adjustments authority under section 1886(d)(5)(I)(i) of the Act to apply reductions of 0.2 percent (or a 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 XI.C. of the preamble of this final rule for a complete discussion of our policy on admission and medical review criteria for hospital inpatient services under Medicare Part A.

III. 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 capital Federal rate for FY 2014, which is 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 Federal Hospital Inpatient Capital-Related Prospective Payment Rate Update

In the discussion that follows, we explain the factors that we used to determine the capital Federal rate for FY 2014. In particular, we explain why the FY 2014 capital Federal rate increases approximately 0.9 percent, compared to the FY 2013 capital Federal rate. As discussed in the impact analysis in Appendix A to this final rule, we estimate that capital payments per discharge will increase 1.6 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 update factor for FY 2014 under that framework is 0.9 percent based on the best data available at this time. The update factor under that framework is based on a projected 1.2 percent increase in the revised and rebased FY 2010-based CIPI (discussed in more detail in section IV.D. of the preamble of this final 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 applying 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
- The annual DRG reclassification and recalibration changes may not be budget neutral (''reclassification effect'').

We define real case-mix change as actual changes in the mix (and resource requirements) of Medicare patients as opposed to changes in documentation and coding behavior that result in assignment of cases to higher-weighted DRGs, but do not reflect higher resource requirements. The capital update framework includes the same case-mix index adjustment used in the former operating IPPS update framework (as discussed in the May 18, 2004 IPPS proposed rule for FY 2005 (69 FR 28816)). (We no longer use an update framework to make a recommendation for updating the operating IPPS standardized amounts as discussed in section II. of Appendix B to the FY 2006 IPPS final rule (70 FR 47707).)

For FY 2014, we are projecting a 0.5 percent total increase in the case-mix index. We estimated that the real case-mix increase will also equal 0.5 percent for FY 2014. The net adjustment for change in case-mix is the difference between the projected real increase in case-mix and the projected total increase in case-mix. Therefore, as we proposed, the net adjustment for case-mix change in FY 2014 is 0.0 percentage point.

The capital update framework also contains an adjustment for the effects of DRG reclassification and recalibration. This adjustment is intended to remove the effect on total payments of prior year's changes to the DRG classifications and relative weights, in order to retain budget neutrality for all case-mix index-related changes other than those due to patient severity of illness. Due to the lag time in the availability of data, there is a 2-year lag in data used to determine the adjustment for the effects of DRG reclassification and recalibration. For example, we have data available to evaluate the effects of the FY 2012 DRG reclassification and recalibration as part of our update for FY 2014. We estimate that FY 2012 DRG reclassification and recalibration resulted in no change in the case-mix when compared with the case-mix index that would have resulted if we had not made the reclassification and recalibration changes to the DRGs. Therefore, as we proposed, we are making a 0.0 percentage point adjustment for reclassification and recalibration in the update framework for FY 2014.

The capital update framework also contains an adjustment for forecast error. The input price index forecast is based on historical trends and relationships ascertainable at the time the update factor is established for the upcoming year. In any given year, there may be unanticipated price fluctuations that may result in differences between the actual increase in prices and the forecast used in calculating the update factors. In setting a prospective payment rate under the framework, we make an adjustment for forecast error only if our estimate of the change in the capital input price index for any year is off by 0.25 percentage point or more. There is a 2-year lag between the forecast and the availability of data to develop a measurement of the forecast error. A forecast error of −0.3 percentage point was calculated for the FY 2014 update. That is, current historical data indicate that the forecasted FY 2012 rate-of-increase of the FY 2006-based CIPI (1.5 percent) used in calculating the FY 2012 update factor slightly overstated the actual realized FY 2012 price increases of the FY 2006-based CIPI (1.2 percent) by 0.3 percentage point because the prices associated with both the depreciation and interest cost categories grew more slowly than anticipated. Historically, when forecast error of the CIPI is greater than 0.25 percentage point in absolute terms, it is reflected in the update recommended under this framework. Therefore, as we proposed, we are making a −0.3 percentage point adjustment for forecast error in the update for FY 2014.

Under the capital IPPS update framework, we also make an adjustment for changes in intensity. Historically, we calculated this adjustment using the same methodology and data that were used in the past under the framework for operating IPPS. The intensity factor for the operating update framework reflected how hospital services are utilized to produce the final product, that is, the discharge. This component accounts for changes in the use of quality-enhancing services, for changes within DRG severity, and for expected modification of practice patterns to remove noncost-effective services. Our intensity measure is based on a 5-year average.

We calculate case-mix constant intensity as the change in total cost per discharge, adjusted for price level changes (the CIPI for hospital and related services) and changes in real case-mix. Without reliable estimates of the proportions of the overall annual intensity increases that are due, respectively, to ineffective practice patterns and the combination of quality-enhancing new technologies and complexity within the DRG system, we assume that one-half of the annual increase is due to each of these factors. The capital update framework thus provides an add-on to the input price index rate of increase of one-half of the estimated annual increase in intensity, to allow for increases within DRG severity and the adoption of quality-enhancing technology.

In this final rule, we are continuing to use a Medicare-specific intensity measure that is based on a 5-year adjusted average of cost per discharge for FY 2014 (we refer readers to the FY 2011 IPPS/LTCH PPS final rule (75 FR 50436) for a full description of our Medicare-specific intensity measure). Specifically, for FY 2014, we are using an intensity measure that is based on an average of cost per discharge data from the 5-year period beginning with FY 2006 and extending through FY 2011. Based on these data, we estimated that case-mix constant intensity declined during FYs 2006 through 2011. In the past, when we found intensity to be declining, we believed a zero (rather than a negative) intensity adjustment was appropriate. Consistent with this approach, because we estimate that intensity declined during that 5-year period, we believe it is appropriate to continue to apply a zero intensity adjustment for FY 2014. Therefore, as we proposed, we are making a 0.0 percentage point adjustment for intensity in the update for FY 2014.

Above, we described the basis of the components used to develop the 0.9 percent capital update factor under the capital update framework for FY 2014 as shown in the table below.

CMS FY 2014 UPDATE FACTOR TO THE CAPITAL FEDERAL RATE

Capital Input Price Index*	1.2
Intensity	0.0
Case-Mix Adjustment Factors:	
Real Across DRG Change	−0.5
Projected Case-Mix Change	0.5
Subtotal	1.2
Effect of FY 2012 Reclassification and Recalibration	0.0
Forecast Error Correction	−0.3
Total Update	0.9

*The capital input price index is based on the revised and rebased FY 2010-based CIPI discussed in section IV.D. of the preamble of this final rule.

b. Comparison of CMS and MedPAC Update Recommendation

In its March 2013 Report to Congress, MedPAC did not make a specific update recommendation for capital IPPS payments

for FY 2014. (We refer readers to MedPAC's Report to the Congress: Medicare Payment Policy, March 2013, Chapter 3.)

2. Outlier Payment Adjustment Factor

Section 412.312(c) establishes a unified outlier payment methodology for inpatient operating and inpatient capital-related costs. A single set of thresholds is used to identify outlier cases for both inpatient operating and inpatient capital-related payments. Section 412.308(c)(2) provides that the standard Federal rate for inpatient capital-related costs be reduced by an adjustment factor equal to the estimated proportion of capital-related outlier payments to total inpatient capital-related PPS payments. The outlier thresholds are set so that operating outlier payments are projected to be 5.1 percent of total operating IPPS DRG payments.

For FY 2013, we estimated that outlier payments for capital will equal 6.38 percent of inpatient capital-related payments based on the capital Federal rate in FY 2013. Based on the thresholds as set forth in section II.A. of this Addendum, we estimate that outlier payments for capital-related costs would equal 6.07 percent for inpatient capital-related payments based on the capital Federal rate in FY 2014. Therefore, we are applying an outlier adjustment factor of 0.9393 in determining the capital Federal rate for FY 2014. Thus, we estimate that the percentage of capital outlier payments to total capital Federal rate payments for FY 2014 will be slightly lower than the percentage for FY 2013.

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 FY 2014 outlier adjustment of 0.9393 is a 0.33 percent change from the FY 2013 outlier adjustment of 0.9362. Therefore, the net change in the outlier adjustment to the capital Federal rate for FY 2014 is 1.0033 (0.9393/0.9362). Thus, the outlier adjustment will increase the FY 2014 capital Federal rate by 0.33 percent compared to the FY 2013 outlier adjustment.

3. 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 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 FY 2014 GAFs. To achieve budget neutrality for the changes in the national GAFs, based on calculations using updated data, we are applying an incremental budget neutrality adjustment factor of 0.9997 for FY 2014 to the previous cumulative FY 2013 adjustment factor of 0.9904, yielding an adjustment factor of 0.9900 through FY 2014. For the Puerto Rico GAFs, we are applying 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 FY 2014 GAFs to estimated aggregate capital Federal rate payments based on the cumulative effects of the FY 2014 MS–DRG classifications and relative weights and the FY 2014 GAFs. The incremental adjustment factor for DRG classifications and changes in relative weights is 0.9990 both nationally and for Puerto Rico. The cumulative adjustment factors for MS–DRG classifications and changes in relative weights and for changes in the GAFs through FY 2014 are 0.9881 nationally and 1.0076 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 cumulative adjustment factor accounts for the MS–DRG reclassifications and recalibration and for changes in the GAFs. It also incorporates the effects on the 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. Capital Federal Rate for FY 2014

For FY 2013, we established a capital Federal rate of $425.49 (77 FR 53706). We are establishing 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 final rule, we are making 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 on admission and medical review criteria for hospital inpatient services under Medicare Part A.

As a result of the 0.9 percent update, the budget neutrality factors, and the 0.2 percent reduction to offset the estimated additional IPPS expenditures projected to result from our policy on admission and medical review criteria for hospital inpatient services discussed above, we are establishing a national capital Federal rate of $429.31 for FY 2014. The national capital Federal rate for FY 2014 was calculated as follows:

- The FY 2014 update factor is 1.009, that is, the update is 0.9 percent.
- The FY 2014 budget neutrality adjustment factor that is applied to the capital Federal rate for changes in the MS–DRG classifications and relative weights and changes in the GAFs is 0.9987.
- The FY 2014 outlier adjustment factor is 0.9393.
- An 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 on admission and medical review criteria for hospital inpatient services under Medicare Part A.

(We note that, as discussed in section VI.D. of the preamble of this final rule, we are not making an additional MS–DRG documentation and coding adjustment to the capital IPPS Federal rates for FY 2014.)

Because the 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 making additional adjustments in the capital Federal rate for these factors, other than the budget neutrality factor for changes in the MS–DRG classifications and relative weights and for 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 factors and adjustments for FY 2014 affects the computation of the FY 2014 national capital Federal rate in comparison to the FY 2013 national capital Federal rate. The FY 2014 update factor has the effect of increasing the capital Federal rate by 0.9 percent compared to the FY 2013 capital Federal rate. The GAF/DRG budget neutrality adjustment factor has the effect of decreasing the capital Federal rate by 0.13 percent. The FY 2014 outlier adjustment factor has the effect of increasing the capital Federal rate by 0.33 percent

compared to the FY 2013 capital Federal rate. The adjustment to account for the estimated additional IPPS expenditures that are projected to result from our policy on admission and medical review criteria for hospital inpatient services under Medicare Part A has the effect of decreasing the capital Federal rate by 0.2 percent compared to the FY 2013 capital Federal rate. The combined effect of all the changes will increase the national capital Federal rate by 1.90 percent compared to the FY 2013 national capital Federal rate.

COMPARISON OF FACTORS AND ADJUSTMENTS: FY 2013 CAPITAL FEDERAL RATE AND FY 2014 CAPITAL FEDERAL RATE

	FY 2013	FY 2014	Change	Percent change
Update Factor [1]	1.0120	1.0090	1.0090	0.90
GAF/DRG Adjustment Factor [1]	0.9998	0.9987	0.9987	−0.13
Outlier Adjustment Factor [2]	0.9362	0.9393	1.0033	0.33
Adjustment for admission and medical review criteria [3]	N/A	0.9980	0.9980	−0.20
Capital Federal Rate	$425.49	$429.31	1.0190	1.90

[1] The update factor and the GAF/DRG budget neutrality adjustment factors are built permanently into the capital Federal rates. Thus, for example, the incremental change from FY 2013 to FY 2014 resulting from the application of the 0.9987 GAF/DRG budget neutrality adjustment factor for FY 2014 is a net change of 0.9987 (or −0.13 percent).

[2] The outlier reduction factor is not built permanently into the capital Federal rate; that is, the factor is not applied cumulatively in determining the capital Federal rate. Thus, for example, the net change resulting from the application of the FY 2014 outlier adjustment factor is 0.9393/0.9362, or 1.0033 (or 0.33 percent).

[3] The adjustment to account for the estimated additional IPPS expenditures that are projected to result from our policy on admission and medical review criteria for hospital inpatient services under Medicare Part A (discussed in section VI.C. of the preamble of this final rule).

In this final rule, we also are providing the following chart that shows how the final FY 2014 capital Federal rate differs from the proposed FY 2014 capital Federal rate as presented in the FY 2014 IPPS/LTCH PPS proposed rule.

COMPARISON OF FACTORS AND ADJUSTMENTS: PROPOSED FY 2014 CAPITAL FEDERAL RATE AND FINAL FY 2014 CAPITAL FEDERAL RATE

	Proposed	Final	Change	Percent change
Update Factor	1.0090	1.0090	1.0000	0.00
GAF/DRG Adjustment Factor	0.9988	0.9987	0.9999	−0.01
Outlier Adjustment Factor	0.9451	0.9393	0.9938	−0.62
Adjustment for admission and medical review criteria	0.9980	0.9980	1.0000	0.00
Capital Federal Rate	$432.03	$429.31	0.9937	−0.63

6. Special Capital Rate for Puerto Rico Hospitals

Section 412.374 provides for the use of a blended payment system for payments made to hospitals located in Puerto Rico under the PPS 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. Under the broad authority of section 1886(g) of the Act, beginning with discharges occurring on or after October 1, 2004, capital payments made to hospitals located in Puerto Rico are based on a blend of 25 percent of the Puerto Rico capital rate and 75 percent of the capital Federal rate. The Puerto Rico capital rate is derived from the costs of Puerto Rico hospitals only, while the capital Federal rate is derived from the costs of all acute care hospitals participating in the IPPS (including Puerto Rico).

To adjust hospitals' capital payments for geographic variations in capital costs, we apply a GAF to both portions of the blended capital rate. The GAF is calculated using the operating IPPS wage index, and varies depending on the labor market area or rural area in which the hospital is located. We use the Puerto Rico wage index to determine the GAF for the Puerto Rico part of the capital-blended rate and the national wage index to determine the GAF for the national part of the blended capital rate.

Because we implemented a separate GAF for Puerto Rico in FY 1998, we also apply separate budget neutrality adjustment factors for the national GAF and for the Puerto Rico GAF. However, we apply the same budget neutrality adjustment factor for MS–DRG reclassifications and recalibration nationally and for Puerto Rico. The budget neutrality adjustment factors for the national GAF and for the Puerto Rico GAF, and the budget neutrality factor for MS–DRG reclassifications and recalibration (which is the same nationally and for Puerto Rico) is discussed above in section III.A.3. of this Addendum.

In computing the payment for a particular Puerto Rico hospital, the Puerto Rico portion of the capital rate (25 percent) is multiplied by the Puerto Rico-specific GAF for the labor market area in which the hospital is located, and the national portion of the capital rate (75 percent) is multiplied by the national GAF for the labor market area in which the hospital is located (which is computed from national data for all hospitals in the United States and Puerto Rico).

For FY 2013, the special capital rate for hospitals located in Puerto Rico was $207.25 (77 FR 53707). With the changes we are making to the other factors used to determine the capital Federal rate (including the adjustment to account for the estimated additional IPPS expenditures that are projected to result from our policy on admission and medical review criteria for hospital inpatient services under Medicare Part A (discussed in section IX.C. of the preamble of this final rule)), the FY 2014 special capital rate for hospitals in Puerto Rico is $209.82.

B. Calculation of the Inpatient Capital-Related Prospective Payments for FY 2014

For purposes of calculating payments for each discharge during FY 2014, the capital Federal rate is adjusted as follows: (Standard Federal Rate) × (DRG weight) × (GAF) × (COLA for hospitals located in Alaska and Hawaii) × (1 + DSH Adjustment Factor + IME Adjustment Factor, if applicable). The result is the adjusted capital Federal rate.

Hospitals also may receive outlier payments for those cases that qualify under the thresholds established for each fiscal year. Section 412.312(c) provides for a single set of thresholds to identify outlier cases for both inpatient operating and inpatient capital-related payments. The outlier thresholds for FY 2014 are in section II.A. of this Addendum. For FY 2014, a case would qualify as a cost outlier if the cost for the case plus the (operating) IME and DSH payments (including both the empirically justified Medicare DSH payment and the estimated uncompensated care payment, as discussed in section II.A.4.g.(1) of this Addendum) is greater than the prospective payment rate for the MS–DRG plus the fixed-loss amount of $21,748.

Currently, as provided under § 412.304(c)(2), we pay a new hospital 85

percent of its reasonable costs during the first 2 years of operation unless it elects to receive payment based on 100 percent of the capital Federal rate. Effective with the third year of operation, we pay the hospital based on 100 percent of the capital Federal rate (that is, the same methodology used to pay all other hospitals subject to the capital PPS).

C. Capital Input Price Index

1. Background

Like the operating input price index, the capital input price index (CIPI) is a fixed-weight price index that measures the price changes associated with capital costs during a given year. The CIPI differs from the operating input price index in one important aspect—the CIPI reflects the vintage nature of capital, which is the acquisition and use of capital over time. Capital expenses in any given year are determined by the stock of capital in that year (that is, capital that remains on hand from all current and prior capital acquisitions). An index measuring capital price changes needs to reflect this vintage nature of capital. Therefore, the CIPI was developed to capture the vintage nature of capital by using a weighted-average of past capital purchase prices up to and including the current year.

We periodically update the base year for the operating and capital input price indexes to reflect the changing composition of inputs for operating and capital expenses. As we proposed, in this final rule, we are rebasing and revising the CIPI to a FY 2010 base year to reflect the more current structure of capital costs in hospitals. A complete discussion of this rebasing is provided in section IV.D. of the preamble of this final rule. The CIPI was last rebased to FY 2006 in the FY 2010 IPPS/RY 2010 LTCH PPS final rule (74 FR 44021).

2. Forecast of the CIPI for FY 2014

Based on the latest forecast by IHS Global Insight, Inc. (second quarter of 2013), we are forecasting the FY 2010-based CIPI to increase 1.2 percent in FY 2014. This reflects a projected 1.9 percent increase in vintage-weighted depreciation prices (building and fixed equipment, and movable equipment), and a projected 2.8 percent increase in other capital expense prices in FY 2014, partially offset by a projected 2.3 percent decline in vintage-weighted interest expenses in FY 2014. The weighted average of these three factors produces the forecasted 1.2 percent increase for the FY 2010-based CIPI as a whole in FY 2014.

IV. Changes to Payment Rates for Excluded Hospitals: Rate-of-Increase Percentages for FY 2014

Historically, certain hospitals and hospital units excluded from the prospective payment system received payment for inpatient hospital services they furnished on the basis of reasonable costs, subject to a rate-of-increase ceiling. An annual per discharge limit (the target amount as defined in § 413.40(a)) was set for each hospital or hospital unit based on the hospital's own cost experience in its base year, and updated annually by a rate-of-increase percentage. The updated target amount for that period was multiplied by the Medicare discharges during that period and applied as an aggregate upper limit (the ceiling as defined in § 413.40(a)) on total inpatient operating costs for a hospital's cost reporting period. Prior to October 1, 1997, these payment provisions applied consistently to certain categories of excluded providers, which included rehabilitation hospitals and units (now referred to as IRFs), psychiatric hospitals and units (now referred to as IPFs), LTCHs, children's hospitals, and cancer hospitals.

Payments for services furnished in children's hospitals and cancer hospitals that are excluded from the IPPS continue to be subject to the rate-of-increase ceiling based on the hospital's own historical cost experience. (We note that, in accordance with § 403.752(a), RNHCIs are also subject to the rate-of-increase limits established under § 413.40 of the regulations.)

In the FY 2014 IPPS/LTCH PPS proposed rule (78 FR 27777), we proposed that the FY 2014 rate-of-increase percentage for updating the target amounts for the 11 cancer hospitals, children's hospitals, and RNHCIs would be the estimated percentage increase in the FY 2014 IPPS operating market basket, in accordance with applicable regulations at § 413.40. As described in section IV. of the preamble of the proposed rule, we proposed to revise and rebase the IPPS operating market basket to a FY 2010 base year. Therefore, we proposed to use the percentage increase in the FY 2010-based IPPS operating market basket to update the target amounts for children's hospitals, 11 cancer hospitals, and RNHCIs for FY 2014 and subsequent fiscal years. Accordingly, we proposed that the FY 2014 rate-of-increase percentage to be applied to the target amount for these cancer hospitals, children's hospitals, and RNHCIs would be the FY 2014 percentage increase in the FY 2010-based IPPS operating market basket. Based on IHS Global Insight, Inc.'s 2013 first quarter forecast, we estimated that the FY 2010-based IPPS operating market basket update for FY 2014 was 2.5 percent (that is, the estimate of the market basket rate-of-increase). However, we proposed that if more recent data became available for the final rule, we would use them to calculate the IPPS operating market basket update for FY 2014. Therefore, based on IHS Global Insight, Inc.'s 2013 second quarter forecast, with historical data through the 2013 first quarter, we estimate that the final FY 2010-based IPPS operating market basket update for FY 2014 is 2.5 percent (that is, the estimate of the market basket rate-of-increase). For cancer and children's hospitals and RNHCIs, the final FY 2014 rate-of-increase percentage that will be applied to the FY 2013 target amounts in order to determine the final FY 2014 target amount is 2.5 percent.

IRFs, IPFs, and LTCHs were previously paid under the reasonable cost methodology. However, the statute was amended to provide for the implementation of prospective payment systems for IRFs, IPFs, and LTCHs. In general, the prospective payment systems for IRFs, IPFs, and LTCHs provide transitioning periods of varying lengths of time during which a portion of the prospective payment was based on cost-based reimbursement rules under 42 CFR Part 413 (certain providers do not receive a transition period or may elect to bypass the transition as applicable under 42 CFR Part 412, Subparts N, O, and P.) We note that all of the various transitioning periods provided for under the IRF PPS, the IPF PPS, and the LTCH PPS have ended.

The IRF PPS, the IPF PPS, and the LTCH PPS are updated annually. We refer readers to section VIII. of the preamble of this final rule and section V. of the Addendum to this final rule for the update changes to the Federal payment rates for LTCHs under the LTCH PPS for FY 2014. The annual updates for the IRF PPS and the IPF PPS are issued by the agency in separate **Federal Register** documents.

V. Updates to the Payment Rates for the LTCH PPS for FY 2014

A. LTCH PPS Standard Federal Rate for FY 2014

1. Background

In section VIII. of the preamble of this final rule, we discuss our updates to the payment rates, factors, and specific policies under the LTCH PPS for FY 2014.

Under § 412.523(c)(3)(ii) of the regulations, for LTCH PPS rate years beginning RY 2004 through RY 2006, we updated the standard Federal rate annually by a factor to adjust for the most recent estimate of the increases in prices of an appropriate market basket of goods and services for LTCHs. We established this policy of annually updating the standard Federal rate because, at that time, we believed that was the most appropriate method for updating the LTCH PPS standard Federal rate for years after the initial implementation of the LTCH PPS in FY 2003. Therefore, under § 412.523(c)(3)(ii), for RYs 2004 through 2006, the annual update to the LTCH PPS standard Federal rate was equal to the previous rate year's Federal rate updated by the most recent estimate of increases in the appropriate market basket of goods and services included in covered inpatient LTCH services.

In determining the annual update to the standard Federal rate for RY 2007, based on our ongoing monitoring activity, we believed that, rather than solely using the most recent estimate of the LTCH PPS market basket update as the basis of the annual update factor, it was appropriate to adjust the standard Federal rate to account for the effect of documentation and coding in a prior period that was unrelated to patients' severity of illness (71 FR 27818). Accordingly, we established under § 412.523(c)(3)(iii) that the annual update to the standard Federal rate for RY 2007 was zero percent based on the most recent estimate of the LTCH PPS market basket at that time, offset by an adjustment to account for changes in case-mix in prior periods due to the effect of documentation and coding that were unrelated to patients' severity of illness. For RY 2008 through FY 2011, we also made an adjustment for the effect of documentation and coding that was unrelated to patients' severity of illness in establishing the annual update to the standard Federal rate as set forth in the