DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 412

[CMS–1599–N]

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Medicare Program; Additional Extension of the Payment Adjustment for Low-Volume Hospitals and the Medicare-Dependent Hospital (MDH) Program Under the Hospital Inpatient Prospective Payment Systems (IPPS) for Acute Care Hospitals for Fiscal Year 2014

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

ACTION: Extension of a Payment Adjustment and a Program.

SUMMARY: This document announces changes to the payment adjustment for low-volume hospitals and to the Medicare-dependent hospital (MDH) program under the hospital inpatient prospective payment systems (IPPS) for the second half of FY 2014 (April 1, 2014 through September 30, 2014) in accordance with sections 105 and 106, respectively, of the Protecting Access to Medicare Act of 2014 (PAMA).

DATES: *Effective Date:* June 12, 2014.

Applicability Dates: The provisions described in this document are applicable for discharges on or after April 1, 2014 and on or before September 30, 2014.

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

SUPPLEMENTARY INFORMATION:

I. Background

On April 1, 2014, the Protecting Access to Medicare Act of 2014 (PAMA) (Pub. L. 113–93) was enacted. Section 105 of PAMA extends changes to the payment adjustment for low-volume hospitals for an additional year, through March 31, 2015, that is, through the first 6 months of fiscal year (FY) 2015. Section 106 of PAMA extends the Medicare-dependent, small rural hospital (MDH) program for an additional year, through March 31, 2015, that is, through the first 6 months of FY 2015. This document addresses payment for these programs only for the second half of FY 2014 (April 1, 2014 through September 30, 2014). We proposed to implement the statutory changes for the first half of FY 2015 (October 1, 2014 through March 31, 2015) in the FY 2015 IPPS/LTCH PPS proposed rule that appeared in the May 15, 2014 **Federal Register**.

II. Provisions of the Document

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

1. Background

Section 1886(d)(12) of the Social Security Act (the Act) provides for an additional payment to qualifying low-volume hospitals that are paid under the Inpatient Prospective Payment Systems (IPPS) beginning in FY 2005. Sections 3125 and 10314 of the Affordable Care Act provided for a temporary change in the low-volume hospital payment policy for FYs 2011 and 2012. Section 605 of the American Taxpayer Relief Act of 2012 (ATRA) extended, for FY 2013, the temporary changes in the low-volume hospital payment policy provided for in FYs 2011 and 2012 by the Affordable Care Act. Section 1105 of the Pathway for SGR Reform Act of 2013 extended, for the first 6 months of FY 2014 (that is, through March 31, 2014), the temporary changes in the low-volume hospital payment policy originally provided for by the Affordable Care Act and extended through subsequent legislation.

We addressed the extension of the temporary changes to the low-volume hospital payment policy through March 31, 2014 under the Pathway for SGR Reform Act in an interim final rule with comment period (IFC) that appeared in the March 18, 2014 **Federal Register** (79 FR 15022 through 15025) (hereinafter referred to as the FY 2014 IPPS IFC). In the FY 2014 IPPS IFC, we also amended the regulations at 42 CFR 412.101 to reflect the extension of the temporary changes to the qualifying criteria and the payment adjustment for low-volume hospitals through March 31, 2014 in accordance with section 1105 of the Pathway for SGR Reform Act.

2. Low-Volume Hospital Payment Adjustment Under the Temporary Changes (Originally Provided by the Affordable Care Act) for FYs 2011 Through 2013 and FY 2014 Discharges Occurring Before April 1, 2014

For FYs 2011 and 2012, sections 3125 and 10314 of the Affordable Care Act expanded the definition of low-volume hospital and modified the methodology for determining the payment adjustment for hospitals meeting that definition. Specifically, the provisions of the Affordable Care Act amended the qualifying criteria for low-volume hospitals under section 1886(d)(12)(C)(i) of the Act to specify that, for FYs 2011 and 2012, a hospital qualifies as a low-volume hospital if it is more than 15 road miles from another subsection (d) hospital and has less than 1,600 discharges of individuals entitled to, or enrolled for, benefits under Part A during the fiscal year. In addition, section 1886(d)(12)(D) of the Act, as added by the Affordable Care Act, provides that the low-volume hospital payment adjustment (that is, the percentage increase) is to be determined ''using a continuous linear sliding scale ranging from 25 percent for low-volume hospitals with 200 or fewer discharges of individuals entitled to, or enrolled for, benefits under Part A in the fiscal year to 0 percent for low-volume hospitals with greater than 1,600 discharges of such individuals in the fiscal year.'' We revised the regulations at 42 CFR 412.101 to reflect the changes to the qualifying criteria and the payment adjustment for low-volume hospitals according to the provisions of the Affordable Care Act in the FY 2011 IPPS/LTCH PPS final rule (75 FR 50238 through 50275 and 50414). In addition, we also defined, at § 412.101(a), the term ''road miles'' to mean ''miles'' as defined at § 412.92(c)(1), and clarified existing regulations that a hospital must continue to qualify as a low-volume hospital in order to receive the payment adjustment in that year (that is, it is not based on a one-time qualification).

Section 605 of the ATRA extended the temporary changes in the low-volume hospital payment policy provided for in FYs 2011 and 2012 by the Affordable Care Act for FY 2013, that is, for discharges occurring before October 1, 2013. We announced the extension of the Affordable Care Act amendments to the low-volume hospital payment adjustment requirements under section 1886(d)(12) of the Act for FY 2013 pursuant to section 605 of the ATRA in a notice of extension that appeared in the March 7, 2013 **Federal Register** (78 FR 14689 through 14694).

Section 1105 of the Pathway for SGR Reform Act extended, for the first 6 months of FY 2014 (that is, through March 31, 2014), the temporary changes in the low-volume hospital payment policy originally provided by the Affordable Care Act. In the FY 2014 IPPS IFC (79 FR 15022 through 15025), we implemented the extension of the Affordable Care Act amendments to the low-volume hospital payment policy through March 31, 2014 under the Pathway for SGR Reform Act. In that IFC, we also amended the regulations at 42 CFR 412.101 to reflect the extension of the temporary changes to the qualifying criteria and the payment adjustment for low-volume hospitals through March 31, 2014.

To implement the extension of the temporary change in the low-volume hospital payment policy through the first half of FY 2014 (that is, for discharges occurring through March 31, 2014), in the FY 2014 IPPS IFC we updated the discharge data source used to identify qualifying low-volume hospitals and calculate the payment adjustment (percentage increase) for FY 2014 discharges occurring before April 1, 2014. Specifically, for FY 2014 discharges occurring before April 1, 2014, consistent with our historical policy, qualifying low-volume hospitals and their payment adjustment were determined using Medicare discharge data from the March 2013 update of the FY 2012 MedPAR file, as these data were the most recent data available at the time of the development of the FY 2014 payment rates and factors established in the FY 2014 IPPS/LTCH PPS final rule. Table 14 of the FY 2014 IPPS IFC (which is available only through the Internet on the CMS Web site at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html*) lists the hospitals with fewer than 1,600 Medicare discharges based on that Medicare discharge data and their potential FY 2014 low-volume payment adjustment (for hospitals that also meet the mileage criterion specified at 42 CFR 412.101(b)(2)(ii)).

Similar to our previously established procedure, in the FY 2014 IPPS IFC we implemented the following procedure for a hospital to request low-volume hospital status for FY 2014 discharges occurring before April 1, 2014. In order for the applicable low-volume percentage increase to be applied to payments for its discharges beginning on or after October 1, 2013 (that is, the beginning of FY 2014), a hospital must have made its request for low-volume hospital status in writing and this request must have been received by its Medicare Administrative Contractor (MAC) no later than March 31, 2014. Requests for low-volume hospital status for FY 2014 discharges occurring before April 1, 2014 that were received by the MAC after March 31, 2014 were to be processed by the MAC; however, the hospital would not be eligible to have the low-volume hospital payment adjustment at § 412.101(c)(2) applied to its FY 2014 discharges occurring before April 1, 2014. We also explained that the low-volume hospital payment adjustment at § 412.101(c)(2) would not be prospectively applied in determining payments for the hospital's FY 2014 discharges, because, at that time, beginning on April 1, 2014, the temporary changes to the low-volume hospital payment policy provided for by the Pathway for SGR Reform Act would have expired and the low-volume hospital definition and payment methodology would have reverted back to the statutory requirements that were in effect prior to the amendments made by the Affordable Care Act. If the hospital would have otherwise met the criteria to qualify as a low-volume hospital under the temporary changes to the low-volume hospital policy, the MAC was to notify the hospital that, although the hospital met the low-volume hospital criteria set forth at § 412.101(b)(2)(ii) and would have had low-volume hospital status within 30 days from the date of the determination, the hospital did not meet the criteria for low-volume hospital status applicable for discharges occurring on or after April 1, 2014 at that time (79 FR 15022 through 15025).

3. Implementation of the Extension of the Temporary Changes to the Low-Volume Hospital Payment Adjustment for FY 2014 Discharges Occurring on or After April 1, 2014 Through September 30, 2014

Section 105 of the PAMA (Pub. L. 113–93) extends, for an additional year (that is, through March 31, 2015), the temporary changes in the low-volume hospital payment policy provided for in FYs 2011 and 2012 by the Affordable Care Act and extended through FY 2013 by the ATRA and the first half of FY 2014 by the Pathway for SGR Reform Act. Prior to the enactment of the PAMA, beginning with discharges occurring on or after April 1, 2014, the low-volume hospital definition and payment adjustment methodology was to return to the policy established under statutory requirements that were in effect prior to the amendments made by the Affordable Care Act as extended by subsequent legislation. Section 105 of the PAMA extends the Affordable Care Act amendments to the low-volume hospital payment policy by amending sections 1886(d)(12)(B), (C)(i), and (D) of the Act. Specifically, section 105 of the PAMA amends section 1886(d)(12)(B) of the Act by striking ''in the portion of fiscal year 2014 beginning on April 1, 2014, fiscal year 2015, and subsequent fiscal years'' and inserting ''in fiscal year 2015 (beginning on April 1, 2015), fiscal year 2016, and subsequent fiscal years''; amends section 1886(d)(12)(C)(i) by striking ''fiscal years 2011, 2012, and 2013, and the portion of fiscal year 2014 before'' and inserting ''fiscal years 2011 through 2014 and fiscal year 2015 (before April 1, 2015),'' each place it appears; and amends section 1886(d)(12)(D) of the Act by striking ''fiscal years 2011, 2012, and 2013, and the portion of fiscal year 2014 before April 1, 2014,'' and inserting ''fiscal years 2011 through 2014 and fiscal year 2015 (before April 1, 2015),''.

In the FY 2015 IPPS/LTCH PPS proposed rule (79 FR 28090 through 28092), we proposed to implement the extension of the temporary changes to the low-volume hospital payment policy for the first half of FY 2015 and stated our intent to address the extension of those changes for the second half of FY 2014 (that is, from April 1, 2014 through September 30, 2014) as provided for by the PAMA in a forthcoming **Federal Register** notice. In that proposed rule, we also proposed to make conforming changes to the existing regulations text at § 412.101 to reflect the extension of the changes to the qualifying criteria and the payment adjustment methodology for low-volume hospitals through the first half of FY 2015 (that is, through March 31, 2015) in accordance with section 105 of the PAMA. Specifically, we proposed to revise paragraphs (b)(2)(i), (b)(2)(ii), (c)(1), (c)(2), and (d) of § 412.101. Under these proposed changes to § 412.101, beginning with FY 2015 discharges occurring on or after April 1, 2015, consistent with section 1886(d)(12) of the Act, as amended, the low volume hospital qualifying criteria and payment adjustment methodology would revert to that which was in effect prior to the amendments made by the Affordable Care Act and subsequent legislation (that is, the low-volume hospital payment policy in effect for FYs 2005 through 2010).

To implement the extension of the temporary change in the low-volume hospital payment policy for the last 6 months of FY 2014 provided for by the PAMA, we are using the same data source to identify qualifying low-volume hospitals and calculate the payment adjustment (percentage increase) that was used to identify qualifying low-volume hospitals and calculate the payment adjustment for discharges that occurred during the first half of FY 2014 (that is, FY 2012 Medicare discharge data from the March 2013 update of the MedPAR files), as these data were the most recent data available at the time of the development of the FY 2014 payment rates and factors established in the FY 2014 IPPS/LTCH PPS final rule. This is consistent with our policy at § 412.101(b)(2)(ii), which states that a hospital's Medicare discharges from the most recently available MedPAR data, as determined by CMS, are used to determine if the hospital meets the discharge criteria to

receive the low-volume payment adjustment in the current year. Accordingly, in Table 14 of this document (which is available only through the Internet on the CMS Web site at *http://www.cms.hhs.gov/AcuteInpatientPPS/01_overview.asp*), we are providing the list of the subsection (d) hospitals with fewer than 1,600 Medicare discharges based on the March 2013 update of the FY 2012 MedPAR files and their FY 2014 low-volume payment adjustment, if eligible (Table 14 was originally made available in connection with the FY 2014 IPPS IFC that appeared in the March 18, 2014 **Federal Register**). We note that the list of hospitals with fewer than 1,600 Medicare discharges in Table 14 does not reflect whether or not the hospital meets the mileage criterion. A hospital also must be located more than 15 road miles from any other subsection (d) hospital in order to qualify for a low-volume hospital payment adjustment for FY 2014 discharges occurring on or after April 1, 2014.

A hospital that qualified for the low-volume hospital payment adjustment for its FY 2014 discharges occurring on or after October 1, 2013 through March 31, 2014 does not need to notify its MAC and will continue to receive the applicable low-volume hospital payment adjustment for its FY 2014 discharges occurring on or after April 1, 2014, without reapplying, provided it continues to meet the mileage criterion (that is, the hospital continues to be located more than 15 road miles from any other subsection (d) hospital).

For a hospital that did not qualify for the low-volume hospital payment adjustment for its FY 2014 discharges occurring on or after October 1, 2013 through March 31, 2014, in order to receive a low-volume hospital payment adjustment under § 412.101, consistent with our previously established procedure, we are continuing to require a hospital to notify and provide documentation to its MAC that it meets the mileage criterion. Specifically, the hospital must make its request for low-volume hospital status in writing to its MAC and provide documentation that it meets the mileage criterion, so that the applicable low-volume percentage increase is applied to payments for its discharges occurring on or after April 1, 2014. This written request must be received by its MAC no later than June 30, 2014 in order for the applicable low-volume percentage increase to be applied to payments for the hospital's discharges beginning on or after April 1, 2014. In addition, a hospital that missed the request deadline for FY 2014 discharges occurring before April 1, 2014 in the FY 2014 IPPS IFC but qualified for the low-volume payment adjustment in FY 2013 may receive a low-volume payment adjustment for its FY 2014 discharges occurring on or after April 1, 2014 without reapplying if it continues to meet the Medicare discharge criterion, based on the March 2013 update of the FY 2012 MedPAR data (shown in Table 14), and the mileage criterion. However, the hospital must send written verification that is received by its MAC no later than June 30, 2014, that it continues meet the mileage criterion, that is, it is located more than 15 miles from any other subsection (d) hospital. This procedure is similar to the procedures we used to implement prior extensions of the Affordable Care Act amendments to the low-volume hospital payment policy in the FY 2014 IPPS IFC (79 FR 15024 through 150025) and the FY 2013 IPPS notice of extension (78 FR 14689).

For requests for low-volume hospital status for FY 2014 discharges occurring on or after April 1, 2014 that are received by the MAC after June 30, 2014, if the hospital meets the criteria to qualify as a low-volume hospital, the MAC will apply the applicable low-volume adjustment in determining payments to the hospital's FY 2014 discharges occurring on or after April 1, 2014 prospectively effective within 30 days of the date of the MAC's low-volume status determination. This procedure is similar to the policy we established for a hospital to request low-volume hospital status for FY 2013 in the FY 2013 IPPS notice of extension (78 FR 14689), as well as for FYs 2011 and 2012 in the FY 2011 IPPS/LTCH PPS final rule (75 FR 50274 through 50275) and the FY 2012 IPPS/LTCH PPS final rule (76 FR 51680), respectively.

The use of a Web-based mapping tool, such as MapQuest, as part of documenting that the hospital meets the mileage criterion for low-volume hospitals, is acceptable. The MAC will determine if the information submitted by the hospital, such as the name and street address of the nearest hospitals, location on a map, and distance (in road miles, as defined in the regulations at § 412.101(a)) from the hospital requesting low-volume hospital status, is sufficient to document that the hospital requesting low-volume hospital status meets the mileage criterion. The MAC may follow up with the hospital to obtain additional necessary information to determine whether or not the hospital meets the low-volume hospital mileage criterion. In addition, the MAC will refer to the hospital's Medicare discharge data determined by CMS (as provided in Table 14, which is available only through the Internet on the CMS Web site at *http://www.cms.hhs.gov/AcuteInpatientPPS/01_overview.asp*) to determine whether or not the hospital meets the discharge criterion, and the amount of the payment adjustment for FY 2014 discharges occurring on or after April 1, 2014, once it is determined that the mileage criterion has been met. The Medicare discharge data shown in Table 14, as well as the Medicare discharge data for all subsection (d) hospitals with claims in the March 2013 update of the FY 2012 MedPAR file, is also available on the CMS Web site for hospitals to view the count of their Medicare discharges. The data can be used to help hospitals decide whether or not to apply for low-volume hospital status.

Program guidance on the systems implementation of these provisions, including changes to PRICER software used to make payments, will be announced in an upcoming transmittal. As stated previously, we proposed to make conforming changes to the existing regulations text at § 412.101 to reflect the extension of the changes to the qualifying criteria and the payment adjustment methodology for low-volume hospitals through the first half of FY 2015 (that is, through March 31, 2015) in accordance with section 105 of the PAMA.

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

1. Background

Section 1885(d)(5)(G) of the Act provides special payment protections, under the IPPS, to Medicare-dependent, small rural hospitals (MDHs). (For additional information on the MDH program and the payment methodology, we refer readers to the FY 2012 IPPS/LTCH PPS final rule (76 FR 51683 through 51684). As we discussed in the FY 2011 IPPS/LTCH PPS final rule (75 FR 50287) and in the FY 2012 IPPS/LTCH PPS final rule (76 FR 51683 through 51684), section 3124 of the Affordable Care Act extended the expiration of the MDH program from the end of FY 2011 (that is, for discharges occurring before October 1, 2011) to the end of FY 2012 (that is, for discharges occurring before October 1, 2012). Under prior law, as specified in section 5003(a) of Pub. L. 109–171 (DRA 2005), the MDH program was to be in effect through the end of FY 2011 only.

Since the extension of the MDH program through FY 2012 provided by section 3124 of the ACA, the MDH program has been further extended multiple times. First, section 606 of the

ATRA extended the MDH program through FY 2013 (that is, for discharges occurring before October 1, 2013). (For additional information on the extension of the MDH program for FY 2013 pursuant to section 606 of the ATRA, see the notice of extension that appeared in the March 7, 2013 **Federal Register** (78 FR 14691 through 14692).) Second, section 1106 of the Pathway for SGR Reform Act of 2013 extended the MDH program through the first half of FY 2014 (that is, for discharges occurring before April 1, 2014). In the FY 2014 IPPS IFC, we discussed the 6-month extension of the MDH program from October 1, 2013 through March 31, 2014 provided by the Pathway for SGR Reform Act of 2013 (79 FR 15025 through 15027). In that IFC, we explained how providers may be affected by this extension of the program and described the steps to reapply for MDH status for FY 2014, as applicable. Generally, a provider that was classified as an MDH as of September 30, 2013 was reinstated as an MDH effective October 1, 2013, with no need to reapply for MDH classification. However, if the MDH had classified as a sole community hospital (SCH) or cancelled its rural classification under § 412.103(g) effective on or after October 1, 2013, the effective date of MDH status may not be retroactive to October 1, 2013.

Lastly, and under current law, section 106 of the PAMA provides for a 1-year extension of the MDH program effective from April 1, 2014 to March 31, 2015. Specifically, section 106 of the PAMA amended sections 1886(d)(5)(G)(i) and 1886(d)(5)(G)(ii)(II) of the Act by striking ''April 1, 2014'' and inserting ''April 1, 2015''. Section 106 of the PAMA also made conforming amendments to sections 1886(b)(3)(D)(i) and 1886(b)(3)(D)(iv) of the Act. We note that because the extension provided by section 106 of the PAMA spans 2 fiscal years, that is, FY 2014 and FY 2015, we only address the 6-month extension in FY 2014 in this document. The extension of the MDH program through the first half of FY 2015 was addressed in the FY 2015 IPPS/LTCH PPS proposed rule (79 FR 28104 through 28105), where we also proposed to make the conforming changes to the regulations at § 412.108(a)(1) and (c)(2)(iii) to reflect the statutory extension of the MDH program through the first half FY 2015 as provided by section 106 of the PAMA.

2. Provisions of the PAMA

Prior to the enactment of the PAMA, under section 1106 of the Pathway to SGR Reform Act of 2013, the MDH program authorized by section 1886(d)(5)(G) of the Act was set to expire midway through FY 2014 (that is, March 31, 2014). Section 106 of the PAMA amended sections 1886(d)(5)(G)(i) and 1886(d)(5)(G)(ii)(II) of the Act to provide for an additional 1-year extension of the MDH program, effective from April 1, 2014 through March 31, 2015. Section 106 of the PAMA also made conforming amendments to sections 1886(b)(3)(D)(i) and 1886(b)(3)(D)(iv) of the Act.

As noted previously, this document addresses the portion of the MDH program extension that includes the last 6 months of FY 2014 as provided by section 106 of PAMA. Consistent with our implementation of previous MDH extensions (see 79 FR 15025 through 15027 and 78 FR 14691 through 14692), generally, providers that were classified as MDHs as of the anticipated expiration of the MDH provision (that is, as of March 31, 2014) will be reinstated as MDHs effective April 1, 2014 with no need to reapply for MDH classification. However, in the following two situations, the effective date of MDH status may not be retroactive to April 1, 2014.

a. MDHs That Classified as Sole Community Hospitals (SCHs) on or After April 1, 2014

Our regulations at § 412.92(b)(2)(v) would have permitted an MDH that applied for reclassification as an SCH by March 1, 2014 to have such status be effective on April 1, 2014. MDHs that applied by the March 1, 2014 deadline and were approved for SCH classification received SCH status effective April 1, 2014. Hospitals that applied for SCH status after the March 1, 2014 SCH application deadline would have been subject to the usual effective date for SCH classification, that is, 30 days after the date of CMS' written notification of approval, resulting in an effective date of SCH status after April 1, 2014.

In order to be reclassified as an MDH, these hospitals must first cancel their SCH status according to § 412.92(b)(4), because a hospital cannot be both an SCH and an MDH, and then reapply and be approved for MDH status under § 412.108(b). Under § 412.92(b)(4), a hospital's cancellation of its SCH classification becomes effective no later than 30 days after the date the hospital submits its request. Under § 412.108(b)(3), the Medicare contractor will make a determination regarding whether a hospital meets the criteria for MDH status and notify the hospital within 90 days from the date that it receives the hospital's request and all of the required documentation. Under § 412.108(b)(4), a determination of MDH status made by the Medicare contractor is effective 30 days after the date the fiscal intermediary (**Note:** fiscal intermediaries have been replaced by Medicare Administrative Contractors (MACs)) provides written notification to the hospital.

b. MDHs That Requested a Cancellation of Their Rural Classification Under § 412.103(b)

One of the criteria to be classified as an MDH is that the hospital must be located in a rural area. To qualify for MDH status, some MDHs reclassified from an urban to a rural hospital designation, under the regulations at § 412.103(b). With the anticipated March 31, 2014 expiration of the MDH provision prior to the enactment of the PAMA, some of these providers may have requested a cancellation of their rural classification. Therefore, in order to qualify for MDH status, these hospitals must again request to be reclassified as rural under § 412.103(b) and must also reapply for MDH status under § 412.108(b).

As noted previously, under § 412.108(b)(3), the Medicare contractor will make a determination regarding whether a hospital meets the criteria for MDH status and notify the hospital within 90 days from the date that it receives the hospital's request and all of the required documentation. Under § 412.108(b)(4), a determination of MDH status made by the Medicare contractor is effective 30 days after the date the fiscal intermediary (MAC) provides written notification to the hospital.

Any provider that falls within either of the two exceptions listed previously may not have its MDH status automatically reinstated effective April 1, 2014. That is, if a provider reclassified to SCH status or cancelled its rural status effective April 1, 2014, its MDH status will not be retroactive to April 1, 2014, but will instead be applied prospectively, based on the date the hospital is notified that it again meets the requirements for MDH status, in accordance with § 412.108(b)(4), after the hospital reapplies for MDH status. Once granted, this MDH status will remain in effect through March 31, 2015, subject to the requirements at § 412.108. However, if a provider reclassified to SCH status or cancelled its rural status effective on a date later than April 1, 2014, MDH status will be reinstated effective from April 1, 2014, but will end on the date on which the provider changed its status to an SCH or cancelled its rural status. Those hospitals may also reapply for MDH

status to be effective again 30 days from the date the hospital is notified of the determination, in accordance with § 412.108(b)(4). Once granted, this status will remain in effect through March 31, 2015 subject to the requirements at § 412.108. Providers that fall within either of the two exceptions, in order to reclassify as an MDH, will have to reapply for MDH status according to the classification procedures in 42 CFR 412.108(b). Specifically, the regulations at § 412.108(b) require the following:

- The hospital submit a written request along with qualifying documentation to its contractor to be considered for MDH status.
- The contractor make its determination and notify the hospital within 90 days from the date that it receives the request for MDH classification and all required documentation.
- The determination of MDH status be effective 30 days after the date of the contractor's written notification to the hospital.

The following are examples of various scenarios that illustrate how and when MDH status under section 106 of the PAMA will be determined for hospitals that were MDHs as of the anticipated March 31, 2014 expiration of the MDH program:

Example 1: Hospital A was classified as an MDH as of the anticipated March 31, 2014 expiration of the MDH program. Hospital A retained its rural classification and did not reclassify as an SCH. Hospital A's MDH status will be automatically reinstated retroactively to April 1, 2014.

Example 2: Hospital B was classified as an MDH as of the anticipated March 31, 2014 expiration of the MDH program. Per the regulations at § 412.92(b)(2)(v) and in anticipation of the expiration of the MDH program, Hospital B applied for reclassification as an SCH by March 1, 2014, and was approved for SCH status effective on April 1, 2014. Hospital B's MDH status will not be automatically reinstated. In order to reclassify as an MDH, Hospital B must first cancel its SCH status, in accordance with § 412.92(b)(4), and reapply for MDH status under the regulations at § 412.108(b).

Example 3: Hospital C was classified as an MDH as of the anticipated March 31, 2014 expiration of the MDH program. Hospital C missed the application deadline of March 1, 2014 for reclassification as an SCH under the regulations at § 412.92(b)(2)(v) and was not eligible for its SCH status to be effective as of April 1, 2014. The MAC approved Hospital C's request for SCH status effective May 16, 2014. Hospital C's MDH status will be reinstated but only for the portion of time during which it met the criteria for MDH status. Hospital C's MDH status will be reinstated effective April 1, 2014 through May 15, 2014, and its MDH status will be cancelled effective May 16, 2014. In order to reclassify as an MDH, Hospital C must cancel its SCH status, in accordance § 412.92(b)(4), and reapply for MDH status under the regulations at § 412.108(b).

Example 4: Hospital D was classified as an MDH as of the anticipated March 31, 2014 expiration of the MDH program. In anticipation of the expiration of the MDH program, Hospital D requested that its rural classification be cancelled per the regulations at § 412.103(g). Hospital D's rural classification was cancelled effective April 1, 2014. Hospital D's MDH status will not be automatically reinstated. In order to reclassify as an MDH, Hospital D must first request to be reclassified as rural under § 412.103(b) and must reapply for MDH status under § 412.108(b).

Example 5: Hospital E was classified as an MDH as of the anticipated March 31, 2014 expiration of the MDH program. In anticipation of the expiration of the MDH program, Hospital E requested that its rural classification be cancelled per the regulations at § 412.103(g). Hospital E's rural classification is cancelled effective June 1, 2014. Hospital E's MDH status will be reinstated but only for the period of time during which it met the criteria for MDH status. Since Hospital E cancelled its rural status and is classified as urban effective June 1, 2014, MDH status will only be reinstated effective April 1, 2014 through May 31, 2014, and will be cancelled effective June 1, 2014. In order to reclassify as an MDH, Hospital E must first request to be reclassified as rural under § 412.103(b) and must reapply for MDH status under § 412.108(b).

Finally, we note that hospitals continue to be bound by § 412.108(b)(4)(i) through (iii) to report a change in the circumstances under which the status was approved. Thus, if a hospital's MDH status has been extended and it no longer meets the requirements for MDH status, it is required under § 412.108(b)(4)(i) through (iii) to make such a report to its MAC. Additionally, under the regulations at § 412.108(b)(5), Medicare contractors are required to evaluate on an ongoing basis whether or not a hospital continues to qualify for MDH status.

As noted previously, we proposed to make conforming changes to the regulations at § 412.108(a)(1) and (c)(2)(iii) to reflect the statutory extension of the MDH program through March 31, 2015 as provided by section 106 of the PAMA in the FY 2015 IPPS/LTCH PPS proposed rule (79 FR 28104 through 28105). Program guidance on the systems implementation of these provisions, including changes to PRICER software used to make payments, will be announced in an upcoming transmittal. A provider affected by the MDH program extension will receive a notice from its MAC detailing its status in light of the MDH program extension.

We also note that the same approach for the additional payment for uncompensated care under § 412.106(g) discussed in the FY 2014 IPPS IFC (79 FR 15027) will apply in determining MDH payments for FY 2014 discharges occurring on or after April 1, 2014. That is, a pro rata share of the uncompensated care payment amount for that period will be included as part of the Federal rate payment in the comparison of payments under the hospital-specific rate and the Federal rate. Therefore, in making this comparison at cost report settlement, we will include the pro rata share of the uncompensated care payment amount that reflects the period of time the hospital was paid under the MDH program for its FY 2014 discharges occurring on or after April 1, 2014 and before September 30, 2014. This pro rata share will be determined based on the proportion of the applicable Federal fiscal year that is included in that cost reporting period. (For additional information on our implementation of the additional payment for uncompensated care under § 412.106(g), refer to the FY 2014 IPPS/LTCH PPS final rule (78 FR 50620 through 50647) and the interim final rule with comment period titled ''FY 2014 IPPS Changes to Certain Cost Reporting Procedures Related to Disproportionate Share Hospital Uncompensated Care Payments'' that appeared in the October 3, 2013 **Federal Register** (78 FR 61191 through 61194).)

3. The Treatment of MDHs Under the Hospital Readmissions Reduction Program and the Hospital Value-Based Purchasing (VBP) Program for FY 2014

The Hospital Readmissions Reduction Program at section 1886(q) of the Act requires the Secretary to reduce payments to applicable hospitals with excess readmissions effective for discharges beginning on or after October 1, 2012. Section 1886(o) of the Act requires the Secretary to establish a hospital value-based purchasing program (the Hospital Value-Based Purchasing (VBP) Program), effective for discharges beginning on or after October 1, 2012, under which value-based incentive payments are made in a fiscal year to hospitals that meet performance standards established for a performance period for such fiscal year. In general, the adjustments under both the Hospital Readmissions Reduction Program and Hospital VBP Program are applicable to MDHs (except when certain exclusions from the Hospital VBP Program are met).

The payment methodology under the Hospital Readmissions Reduction

Program and Hospital VBP Program applies each program's adjustment factors respectively to the ''base operating DRG payment amount.'' (For additional information on the calculation of the adjustment factor and payment methodology under the Hospital Readmissions Reduction Program, refer to the FY 2013 IPPS/LTCH PPS final rule (77 FR 53374 through 53391). For additional information on the calculation of the adjustment factor and payment methodology under the Hospital VBP Program, refer to the FY 2013 IPPS/LTCH PPS final rule (77 FR 53569 through 53576).) The ''base operating DRG payment amount'' is generally defined as the wage-adjusted DRG operating payment plus any applicable new technology add-on payments (see § 412.152 and § 412.160). For years prior to FY 2014, the statutory provisions related to the definition of ''base operating DRG payment amount'' under section 1886(q) of the Act and section 1886(o) of the Act excluded the difference between an MDH's applicable hospital-specific payment (HSP) rate and the Federal payment rate (referred to as the HSP add-on) from the definition of the base operating DRG payment amount. (MDHs are paid based on the Federal rate or, if higher, the Federal rate plus 75 percent of the amount by which the Federal rate is exceeded by the updated HSP rate from certain specified base years. Thus for MDHs, the HSP add-on for these years is equal to 75 percent of the difference between the Federal rate payment and HSP rate payment. At cost report settlement, the MAC determines which of the payment options yields a higher aggregate payment for an MDH, and also determines the final HSP add-on (if applicable) for that MDH for each cost reporting period.)

The treatment of MDHs under the Hospital Readmissions Reduction Program and the Hospital VBP Program for FY 2014 was not addressed in the FY 2014 IPPS/LTCH PPS final rule because at the time of the publication of that final rule, the MDH program was set to expire at the end of FY 2013. Accordingly, the payment adjustment factors and payment methodology for FY 2014 under both the Hospital Readmissions Reduction Program and Hospital VBP Program established in that final rule were determined without regard to HSP add-on payments to MDHs. That is, for hospitals that were MDHs, the FY 2014 readmissions and value-based incentive payment adjustment factors were calculated using base operating DRG payment amounts that do not include the difference between the HSP payment rate and the Federal payment rate (as applicable). Similarly, in determining payments for MDH discharges occurring in FY 2014, the base operating DRG payment amounts currently also do not include the difference between the HSP payment rate and the Federal payment rate (as applicable).

As discussed previously, subsequent to the publication of the FY 2014 IPPS/LTCH PPS final rule, the MDH program was extended from October 1, 2013, to March 31, 2014, by section 1106 of the Pathway for SGR Reform Act (Pub. L. 113–67) and was further extended an additional year from April 1, 2014, to March 31, 2015, by section 106 of the Protecting Access to Medicare Act of 2014 (Pub. L. 113–93). This legislation extended the MDH program by amending sections 1886(d)(5)(G)(i) and 1886(d)(5)(G)(ii)(II) of the Act and also made conforming amendments to sections 1886(b)(3)(D)(i) and 1886(b)(3)(D)(iv) of the Act. Given the extension of the MDH program for FY 2014, in this document we discuss how the payment methodology under both the Hospital Readmissions Reduction Program and Hospital VBP Program will be applied for MDH discharges occurring during FY 2014, consistent with the sections 1886(q)(2)(B)(i) and 1886(o)(7)(D)(i)(I) of the Act.

We are not revising the FY 2014 readmissions and value-based incentive payment adjustment factors that we established through notice and comment rulemaking in the FY 2014 IPPS/LTCH PPS final rule because at the time we established those factors, the MDH program was set to expire at the end of FY 2013. Therefore, the FY 2014 Readmissions Adjustment Factors in Table 15 of the FY 2014 IPPS/LTCH PPS final rule (as subsequently corrected by the FY 2014 IPPS/LTCH PPS final rule correcting document that appeared in the October 3, 2013 **Federal Register**) and the FY 2014 Hospital VBP Program Adjustment Factors in Table 16B of the FY 2014 IPPS/LTCH PPS final rule (which are only available on the Internet at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html*) will remain unchanged and will continue to apply in determining payments for MDHs' discharges occurring during FY 2014.

However, because a final payment determination for an MDH's cost reporting period is not done until cost report settlement, if an MDH ultimately receives the HSP add-on (that is, its final payment is determined to be the Federal rate payment plus 75 percent of the amount by which the Federal rate is exceeded by the updated HSP rate), then additional adjustments under the Hospital Readmissions Reduction Program and Hospital VBP Program (as applicable) will be made during cost report settlement. If at cost report settlement an MDH ultimately does not receive an HSP add-on for the cost reporting period (that is, its final payment is determined to be the Federal rate payment only), then no additional adjustment (if otherwise applicable) under the Hospital Readmissions Reduction Program and Hospital VBP Program will be made.

III. Collection of Information Requirements

This document does not impose information collection and recordkeeping requirements. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 35).

IV. Waiver of Proposed Rulemaking and Delay of Effective Date

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** and invite public comment prior to a rule taking effect in accordance with section 553(b) of the Administrative Procedure Act (APA) and section 1871 of the Act. In addition, in accordance with section 553(d) of the APA and section 1871(e)(1)(B)(i) of the Act, we ordinarily provide a 30-day delay to a substantive rule's effective date. For substantive rules that constitute major rules, in accordance with 5 U.S.C. 801, we ordinarily provide a 60-day delay in the effective date. None of the processes or effective date requirements apply, however, when the rule in question is interpretive, a general statement of policy, or a rule of agency organization, procedure or practice. They also do not apply when the statute establishes rules to be applied, leaving no discretion or gaps for an agency to fill in through rulemaking. In addition, an agency may waive notice and comment rulemaking, as well as any delay in effective date, when the agency for good cause finds that notice and public comment on the rule as well the effective date delay are impracticable, unnecessary, or contrary to the public interest. In cases where an agency finds good cause, the agency must incorporate a statement of this finding and its reasons in the rule issued.

The policies being publicized in this document do not constitute agency rulemaking. Rather, the statute, as amended by the PAMA, has already

required that the agency make these changes, and we are simply notifying the public of the extension of the changes to the payment adjustment for low-volume hospitals and the MDH program that was effective April 1, 2014. As this document merely informs the public of these extensions, it is not a rule and does not require any notice and comment rulemaking. To the extent any of the policies articulated in this document constitute interpretations of the statute's requirements or procedures that will be used to implement the statute's directive, they are interpretive rules, general statements of policy, and rules of agency procedure or practice, which are not subject to notice and comment rulemaking or a delayed effective date.

However, to the extent that notice and comment rulemaking or a delay in effective date or both would otherwise apply, we find good cause to waive such requirements. Specifically, we find it unnecessary to undertake notice and comment rulemaking in this instance as this document does not propose to make any substantive changes to the policies or methodologies already in effect as a matter of law, but simply applies rate adjustments under the PAMA to these existing policies and methodologies. As the changes outlined in this document have already taken effect, it would also be impracticable to undertake notice and comment rulemaking. For these reasons, we also find that a waiver of any delay in effective date, if it were otherwise applicable, is necessary to comply with the requirements of the PAMA. Therefore, we find good cause to waive notice and comment procedures as well as any delay in effective date, if such procedures or delays are required at all.

V. Regulatory Impact Analysis

A. Introduction

We have examined the impacts of this document as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), Executive Order 13132 on Federalism (August 4, 1999), and the Congressional Review Act (5 U.S.C. 804(2)). Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). Executive Order 13563 emphasizes the importance of quantifying both costs and benefits, of reducing costs, of harmonizing rules, and of promoting flexibility. A regulatory impact analysis (RIA) must be prepared for regulatory actions with economically significant effects ($100 million or more in any 1 year). Although we do not consider this document to constitute a substantive rule or regulatory action, the changes announced in this document are ''economically'' significant, under section 3(f)(1) of Executive Order 12866, and therefore we have prepared a RIA, that to the best of our ability, presents the costs and benefits of the provisions announced in this document. In accordance with Executive Order 12866, this document has been reviewed by the Office of Management and Budget.

The RFA requires agencies to analyze options for regulatory relief of small businesses, if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small government jurisdictions. We estimate that most hospitals and most other providers and suppliers are small entities as that term is used in the RFA. The great majority of hospitals and most other health care providers and suppliers are small entities, either by being nonprofit organizations or by meeting the Small Business Administration definition of a small business (having revenues of less than $7.5 to $35.5 million in any 1 year). (For details on the latest standard for health care providers, we refer readers to page 33 of the Table of Small Business Size Standards at the Small Business Administration's Web site at *http://www.sba.gov/services/contractingopportunities/sizestandardstopics/tableofsize/index.html*.) For purposes of the RFA, all hospitals and other providers and suppliers are considered to be small entities. Individuals and States are not included in the definition of a small entity. We believe that this document will have a significant impact on small entities. Because we acknowledge that many of the affected entities are small entities, the analysis discussed in this section would fulfill any requirement for a final regulatory flexibility analysis. In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. With the exception of hospitals located in certain New England counties, for purposes of section 1102(b) of the Act, we now define a small rural hospital as a hospital that is located outside of an urban area and has fewer than 100 beds.

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) (Pub. L. 104–4) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2014, that threshold is approximately $141 million. This document will not mandate any requirements for State, local, or tribal governments, nor will it affect private sector costs.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. This document will not have a substantial effect on State and local governments.

Although this document merely reflects the implementation of two provisions of the PAMA and does not constitute a substantive rule, we nevertheless prepared this impact analysis in the interest of ensuring that the impacts of these changes are fully understood. The following analysis, in conjunction with the remainder of this document, demonstrates that this document is consistent with the regulatory philosophy and principles identified in Executive Order 12866 and 13563, the RFA, and section 1102(b) of the Act. The changes announced in this document will positively affect payments to a substantial number of small rural hospitals and providers, as well as other classes of hospitals and providers, and the effects on some hospitals and providers may be significant. The impact analysis, which discusses the effect on total payments to IPPS hospitals and providers, is presented in this section.

B. Statement of Need

This document is necessary to update the FY 2014 IPPS final payment policies to reflect changes required by the implementation of two provisions of the PAMA. Section 105 of the PAMA extends the temporary changes to the payment adjustment for low-volume

hospitals from April 1, 2014 through March 31, 2015. Section 106 of the PAMA extends the MDH program from April 1, 2014 through March 31, 2015. As noted previously, program guidance on the systems implementation of these provisions, including changes to PRICER software used to make payments, will be announced in an upcoming transmittal.

C. Overall Impact

The FY 2014 IPPS/LTCH PPS final rule and the FY 2014 IPPS IFC included an impact analysis for the changes to the IPPS included in those rules. This document updates those impacts to the IPPS to reflect the changes made by sections 105 and 106 of the PAMA. Since these sections were not budget neutral, the overall estimates for hospitals have changed from our estimates that were published in the FY 2014 IPPS/LTCH PPS final rule (78 FR 51037) and the FY 2014 IPPS IFC (79 FR 15029 and 15030). We estimate that the changes in the FY 2014 IPPS payments, including the changes announced in this document, will result in an approximate $1.68 billion increase in total payments to IPPS hospitals relative to FY 2013 rather than the $1.44 billion increase we projected in the FY 2014 IPPS IFC (79 FR 15029).

D. Anticipated Effects

The impact analysis reflects the change in estimated payments to IPPS hospitals in FY 2014 as a result of the implementation of sections 105 and 106 of the PAMA relative to the revised estimated FY 2014 payments to IPPS hospitals that were published in the FY 2014 IPPS IFC (79 FR 15029), which include both the estimated FY 2014 IPPS payments from the provisions implemented in that IFC in addition to the estimated FY 2014 IPPS payments published in the FY 2014 IPPS/LTCH PPS final rule (78 FR 51037). As described later in this regulatory impact analysis, FY 2014 IPPS payments to hospitals affected by sections 105 and 106 of the PAMA are projected to increase by $227 million (relative to the FY 2014 payments estimated for these hospitals for the FY 2014 IPPS IFC). Therefore, we project that, on the average, overall IPPS payments in FY 2014 for all hospitals will increase by approximately an additional 0.24 percent as a result of the estimated $227 million increase in payments due to the implementation of sections 105 and 106 of the PAMA compared to the previous estimate of FY 2014 payments to all IPPS hospitals published in the FY 2014 IPPS IFC.

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

The extension of the temporary changes to the payment adjustment for low-volume hospitals (originally provided for by the Affordable Care Act) for the last 6 months of FY 2014 (that is, for April 1, 2014 through September 30, 2014) as provided for under section 105 of the PAMA is a non-budget neutral payment provision. The provisions of the Affordable Care Act expanded the definition of low-volume hospital and modified the methodology for determining the payment adjustment for hospitals meeting that definition. Prior to the enactment of the PAMA, beginning April 1, 2014, the low-volume hospital definition and payment adjustment methodology was to return to the statutory requirements that were in effect prior to the amendments made by the Affordable Care Act and extended by subsequent legislation. With the extension for the last 6 months of FY 2014 (that is, April 1, 2014 through September 30, 2014), provided for by the PAMA, based on FY 2012 claims data (March 2013 update of the MedPAR file), we estimate that approximately 600 hospitals will qualify as a low-volume hospital through September 30, 2014. We project that these hospitals will experience an increase in payments of approximately $161 million as compared to our previous estimate of payments to these hospitals for FY 2014 published in the FY 2014 IPPS IFC.

2. Effects of the Extension of the MDH Program

The extension of the MDH program for the last 6 months of FY 2014 (that is, from April 1, 2014 through September 30, 2014) as provided for under section 106 of the PAMA is a non-budget neutral payment provision. Hospitals that qualify as a MDHs receive the higher of operating IPPS payments made under the Federal standardized amount or the payments made under the Federal standardized amount plus 75 percent of the difference between the Federal standardized amount and the hospital-specific rate. Because this provision is not budget neutral, we estimate that the extension of this payment provision for the last 6 months of FY 2014 will result in a 0.1-percent increase in payments overall. Prior to the extension of the MDH program, there were 198 MDHs, of which 118 were estimated to be paid under the blended payment of the Federal standardized amount and hospital-specific rate through April 1, 2014. Because those 118 MDHs will now receive the blended payment (that is, the Federal standardized amount plus 75 percent of the difference between the Federal standardized amount and the hospital-specific rate) for the second half of FY 2014 (from April 1, 2014 through September 30, 2014), we estimate that those hospitals will experience an overall increase in payments of approximately $66 million as compared to our previous estimate of payments to these hospitals for FY 2014 published in the FY 2014 IPPS IFC.

E. Alternatives Considered

This document provides descriptions of the statutory provisions that are addressed and identifies policies for implementing these provisions. Due to the prescriptive nature of the statutory provisions, no alternatives were considered.

F. Accounting Statement and Table

As required by OMB Circular A–4 (available at *http://www.whitehouse.gov/omb/circulars_a004_a-4*), in Table I, we have prepared an accounting statement showing the classification of expenditures associated with the provisions of this document as they relate to acute care hospitals. This table provides our best estimate of the change in Medicare payments to providers as a result of the changes to the IPPS presented in this document. All expenditures are classified as transfers from the Federal government to Medicare providers. As previously discussed, relative to what was projected in the FY 2014 IPPS IFC, the changes to FY 2014 IPPS payments made by sections 105 and 106 of the PAMA presented in this document are projected to increase FY 2014 payments to IPPS hospitals by approximately $227 million.

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

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

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

Dated: June 3, 2014.

Marilyn Tavenner,

Administrator, Centers for Medicare & Medicaid Services.

Approved: June 11, 2014.

Sylvia M. Burwell,

Secretary, Department of Health and Human Services.

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