

Supporting Statement – Part A

Payment Adjustment for Low-Volume Hospitals Under the Hospital Inpatient Prospective Payment System (IPPS) (CMS-10857)

A. Background

Section 1886(d)(12) of the Act provides for an additional payment to each qualifying low-volume hospital under the IPPS beginning in FY 2005. The additional payment adjustment to a low-volume hospital provided for under section 1886(d)(12) of the Act is in addition to any payment calculated under section 1886 of the Act. The low-volume hospital payment adjustment is implanted in the regulations at 42 CFR 412.101.

Section 50204 of the Bipartisan Budget Act of 2018 (P. L. 115-123) modified the definition of a low-volume hospital and the methodology for calculating the payment adjustment for low-volume hospitals for FYs 2019 through 2022. Subsequent legislation, the Continuing Appropriations and Ukraine Supplemental Appropriations Act, 2023 (P.L. 117-180), the Further Continuing Appropriations and Extensions Act, 2023 (P.L. 117-229) and the Consolidated Appropriations Act (CAA), 2023 (P.L. 117-328), provided an extension through FY 2024.

Specifically, under sections 1886(d)(12)(C)(i) and 1886(d)(12)(C)(i)(III) of the Act, for FYs 2019 through 2024, a low-volume hospital must be more than 15 road miles from another “subsection (d) hospital” and have fewer than 3,800 discharges during the fiscal year. (A “subsection (d) hospital” is defined in section 1886(d)(1)(B) of the Act). In addition, under section 1886(d)(12)(D)(ii) of the Act, for FYs 2019 through 2024, the low-volume hospital payment adjustment is determined using a continuous linear sliding scale ranging from 25 percent for low-volume hospitals with 500 or fewer discharges to 0 percent for low-volume hospitals with greater than 3,800 discharges. This formula set forth in the regulations at § 412.101(c)(3)(ii).

For FY 2025 and subsequent years, under the regulations a low-volume hospital must be more than 25 road miles from another subsection (d) hospital and have fewer than 200 discharges during the fiscal year, and the payment adjustment is an additional 25 percent for each Medicare discharge.

As part of the process to determine eligibility for the low-volume hospital payment adjustment, providers are required annually to provide written documentation to verify that the provider now meets (or continues to meet) the mileage and discharge criteria. There is no standardized collection instrument. The process for requesting and obtaining the low-volume hospital payment adjustment is discussed in the FY 2023 IPPS/LTCH PPS final rule (87 FR 49062 through 49063) and We posted the process for requesting and obtaining on the CMS.gov website www.cms.gov.

We are seeking approval for a new collection for the collecting of information related to low-volume hospitals to determine the verification for the additional payment in accordance with the CAA, 2023.

B. Justification

1. Need and Legal Basis

Section 1886(d)(12) of the Social Security Act (the Act) provides for additional Medicare payments to subsection (d) hospitals that meet the criteria for a low-volume hospital. The low-volume hospital payment adjustment is implemented in the regulations at 42 CFR 412.101, and identifies the criteria used to determine the additional payment adjustment.

Section 4101 of the CAA amended section 1886(d)(12) of the Act by extending the modified definition of a low-volume hospital and the methodology for calculating the payment adjustment for low-volume hospitals through FY 2024.

2. Information Users

The information is submitted by subsection (d) hospitals that are potentially eligible for the low-volume hospital payment adjustment. In general, to be eligible for the low-volume hospital payment adjustments, a hospital must meet the qualifying mileage and discharge criteria under section 1886(d)(12)(C)(i) of the Act. Hospitals currently collect and submit to CMS written documentation regarding the mileage criteria verifying that the hospital is more than 15 road miles from another “subsection (d) hospital”. Medicare Administrative Contractors (MACs) will determine if the hospital meets the criteria for the low-volume hospital payment adjustment as detailed above in the Need and Legal Basis section of this document.

3. Use of Information Technology

The information that hospitals would collect which would be used to determine whether a hospital meets the low-volume hospital payment adjustment qualifying criteria can be done electronically, and therefore submission of information collected can be done through email. Electronic submission of the mileage information eliminates the burden of hard copy reporting and reduces paperwork. The collection of information can be done primarily through internet searches. Additionally, hospitals could collect the information for the mileage data through mapping software, geographic information system (GIS) software, or global positioning systems (GPS) software.

4. Duplication of Efforts

This information collection does not duplicate any other effort and the information cannot be obtained from any other source.

5. Small Businesses

CMS requires all hospitals, regardless of size, to complete the cost report. CMS collects the form as infrequently as possible (annually) and only those data items necessary to determine

the applicable percentage of the payment adjustment are required.

6. Less Frequent Collection

CMS is required by law to provide for an additional payment amount to each low-volume hospital for discharges occurring during that fiscal year. In order to determine if a hospital is eligible to receive the additional payment adjustment, the discharge data from the hospital's cost report and the written documentation regarding the mileage criteria must be reviewed annually. A less frequent collection would adversely affect accurate hospital payments.

7. Special Circumstances

There are no special circumstances needed for this information collection.

8. Federal Register/Outside Consultation

The information collection requirement regarding the payment adjustment for low-volume hospitals was published in the FY 2024 Inpatient Prospective Payment System Proposed Rule (CMS-1785-P), published on May 1, 2023 (88 FR 26658). No comments were received on this proposed information collection. The information collection requirement was finalized in the FY 2024 Inpatient Prospective Payment System Final Rule (CMS-1785-F), and published on August 28, 2023 (88 FR 58640).

9. Payments/Gifts to Respondents

There is no payment or gift being provided to any respondents for the completion of this information collection.

10. Confidentiality

There is no assurance of confidentiality provided to respondents.

11. Sensitive Questions

This information collection does not involve any questions of a sensitive nature.

12. Burden Estimates (Hours & Wages)

For this new collection request, the total burden is the estimated time and effort that would be required for eligible hospitals to gather the appropriate documentation, prepare and submit a request or verification. We estimate that 650 hospitals will be affected by this requirement. This estimate is based on the fact that there are 632 Medicare-certified "subsection (d)" hospitals that received a low-volume hospital payment adjustment in FY 2023 that we estimate will submit a verification of continuing eligibility and we estimate that 18 Medicare-certified "subsection (d)" hospitals will submit an initial request for payment adjustment. We

estimate receiving one (1) request or verification annually from each of the 650 hospitals. Further, we estimate that it will take each hospital approximately 1 hour to gather, prepare, and submit the request or verification. The time estimate for preparation of this application is based upon the professional judgment of staff members at the Centers for Medicare and Medicaid Services. We have calculated the hours as follows:

650 requests x 1 hour each = 650 hours

We estimate that the cost to hospitals should be minimal as we expect hospitals to use internet searches as well as mapping, GPS, or GIS software such as Google Maps, MapQuest, or Waze to collect mileage data. We estimate that hospitals will use their existing communication methods to submit the request or verification. We believe that auditors and accountants will be gathering the information, preparing and submitting these requests or verifications. Based on the most recent Bureau of Labor and Statistics Occupational and Employment Data (May 2021) at <https://www.bls.gov/oes/current/oes132011.htm>, for the position of accountants and auditors, the mean hourly wage for accounts and auditors is \$40.37. We have added 100 percent for fringe and overhead benefits, which calculates to \$80.74 per hour.

We estimate the total annual cost is \$52,481, which is broken out as follows:

- 650 requests/verifications x 1 hour each = 650 hours
- \$80.74 per hour x 650 hours = \$52,481

	Verification of Current Requests Annually	Projected New Requests Annually	Annual Total
Requests/Verifications	632	18	650
Hours per Request	1	1	1
Cost per Hour	\$80.74	\$80.74	\$80.74
Total	\$51,027.68	\$1453.32	\$52,481

13. Capital Costs

There are no capital costs.

14. Cost to Federal Government

The MACs will be responsible for reviewing the requests and verifications received from the hospitals.

CMS, through the MACs, will receive the mileage data submitted by the providers and audit the cost report for discharge data for the 650 hospitals that we estimate will submit a request or verification for the payment adjustment. We estimate that it will take 1 hour for MACs to process each request or verification. This time estimate is based on the professional judgment of staff members at the Centers for Medicare and Medicaid Services.

Using the 2023 Federal Pay Scale, we estimated staff at the GS 11, 12 and 13 levels (step 5) to process the requests/verifications.

(<https://www.opm.gov/policy-data-oversight/pay-leave/salaries-wages/2023/general-schedule>)

The estimated cost to the Federal Government is \$33,508 and is based on the following assumptions:

- 650 requests/verifications x 1 hour each= 650 hours annually
- \$51.55/hour (average salary GS 11, 12, 13) X 650 hours = \$33,508.

15. Changes to Burden

This is a new information collection.

16. Publication/Tabulation Dates

The hospital requests and/or verification data is not to be published for statistical use.

17. Expiration Date

There is no collection instrument used in the collection of this information. The collection provides no instruments to display an expiration date or OMB control number.

18. Certification Statement

There are no exceptions to the certification statement.