DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 412, 482, 485, and 489

[CMS–1599–P]

RIN 0938–AR53

Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Fiscal Year 2014 Rates; Quality Reporting Requirements for Specific Providers; Hospital Conditions of Participation

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

ACTION: Proposed rule.

SUMMARY: We are proposing to revise the Medicare hospital inpatient prospective payment systems (IPPS) for operating and capital-related costs of acute care hospitals to implement changes arising from our continuing experience with these systems. Some of the proposed changes implement certain statutory provisions contained in the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively known as the Affordable Care Act) and other legislation. These proposed changes would be applicable to discharges occurring on or after October 1, 2013, unless otherwise specified in this proposed rule. We also are proposing to update the rate-of-increase limits for certain hospitals excluded from the IPPS that are paid on a reasonable cost basis subject to these limits. The proposed updated rate-of-increase limits would be effective for cost reporting periods beginning on or after October 1, 2013.

We are proposing to update the payment policies and the annual payment rates for the Medicare prospective payment system (PPS) for inpatient hospital services provided by long-term care hospitals (LTCHs) and implement certain statutory changes made by the Affordable Care Act. Generally, these proposed changes would be applicable to discharges occurring on or after October 1, 2013, unless otherwise specified in this proposed rule.

In addition, we are proposing a number of changes relating to direct graduate medical education (GME) and indirect medical education (IME) payments. We are proposing to establish new requirements or revised requirements for quality reporting by specific providers (acute care hospitals, PPS-exempt cancer hospitals, LTCHs, and inpatient psychiatric facilities (IPFs)) that are participating in Medicare.

We are proposing to update policies relating to the Hospital Value-Based Purchasing (VBP) Program and the Hospital Readmissions Reduction Program. In addition, we are proposing to revise the conditions of participation (CoPs) for hospitals relating to the administration of vaccines by nursing staff as well as the CoPs for critical access hospitals relating to the provision of acute care inpatient services.

DATES: *Comment Period:* To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. EDT on June 25, 2013.

Application Deadline for GME FTE Resident Slots from Closed Hospital. Applications from hospitals to receive GME FTE resident slots from a hospital's closure as described in section V.J.3.c. of the preamble of this proposed rule must be received, not postmarked, by 5 p.m. EST on July 25, 2013.

ADDRESSES: When commenting, please refer to file code CMS–1599–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (please choose only one of the ways listed):

1. *Electronically.* You may submit electronic comments on this regulation at *http://www.regulations.gov.* Follow the instructions for ''Comment or Submission'' and enter the file code CMS–1599–P to submit comments on this proposed rule.

2. *By regular mail.* You may mail written comments (one original and two copies) to the following address ONLY:

Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1599–P, P.O. Box 8011, Baltimore, MD 21244–1850.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments (one original and two copies) to the following address ONLY:

Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1599–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

4. *By hand or courier.* If you prefer, you may deliver (by hand or courier) your written comments (one original and two copies) before the close of the comment period to either of the following addresses:

a. Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue SW., Washington, DC 20201.

(Because access to the interior of the HHH Building is not readily available to persons without Federal Government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

b. 7500 Security Boulevard, Baltimore, MD 21244–1850.

If you intend to deliver your comments to the Baltimore address, please call telephone number (410) 786–7195 in advance to schedule your arrival with one of our staff members.

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: Tzvi Hefter, (410) 786–4487, and Ing-Jye Cheng, (410) 786–4548, Operating Prospective Payment, MS–DRGs, Hospital Acquired Conditions (HAC), Wage Index, New Medical Service and Technology Add-On Payments, Hospital Geographic Reclassifications, Graduate Medical Education, Capital Prospective Payment, Excluded Hospitals, Medicare Disproportionate Share Hospital (DSH), and Postacute Care Transfer Issues.

Michele Hudson, (410) 786–4487, and Judith Richter, (410) 786–2590, Long-Term Care Hospital Prospective Payment System and MS–LTC–DRG Relative Weights Issues.

Mollie Knight, (410) 786–7948 and Bridget Dickensheets, (410) 786–8670, Market Basket for IPPS Hospitals and LTCHs Issues.

Siddhartha Mazumdar, (410) 786–6673, Rural Community Hospital Demonstration Program Issues.

James Poyer, (410) 786–2261, Hospital Inpatient Quality Reporting and Hospital Value-Based Purchasing—Program Administration, Validation, and Reconsideration Issues.

Shaheen Halim, (410) 786–0641, Hospital Inpatient Quality Reporting—Measures Issues Except Hospital Consumer Assessment of Healthcare Providers and Systems Issues; and

specified at proposed § 412.101(b)(2)(i). Specifically, to meet the mileage criterion to qualify for the low-volume hospital payment adjustment for FY 2014 and subsequent fiscal years, a hospital must be located more than 25 road miles from the nearest subsection (d) hospital.

For FY 2014, we would continue to use the established process for requesting and obtaining the low-volume hospital payment adjustment. That is, in order to receive a low-volume hospital payment adjustment under § 412.101, a hospital must notify and provide documentation to its fiscal intermediary or MAC that it meets the discharge and distance requirements. The fiscal intermediary or MAC will determine, based on the most recent data available, if the hospital qualifies as a low-volume hospital, so that the hospital will know in advance whether or not it will receive a payment adjustment. The fiscal intermediary or MAC and CMS may review available data, in addition to the data the hospital submits with its request for low-volume hospital status, in order to determine whether or not the hospital meets the qualifying criteria. (For additional details on our established process for the low-volume hospital payment adjustment, we refer readers to the FY 2013 IPPS/LTCH PPS final rule (77 FR 53408).)

Consistent with our previously established procedure, for FY 2014, a hospital must make its request for low-volume hospital status in writing to its fiscal intermediary or MAC by September 1, 2013, in order for the 25-percent low-volume hospital payment adjustment to be applied to payments for its discharges beginning on or after October 1, 2013 (through September 30, 2014). If a hospital's request for low-volume hospital status for FY 2014 is received after September 1, 2013, and if the fiscal intermediary or MAC determines the hospital meets the criteria to qualify as a low-volume hospital, the fiscal intermediary or MAC will apply the 25-percent low-volume hospital payment adjustment to determine the payment for the hospital's FY 2014 discharges, effective prospectively within 30 days of the date of the fiscal intermediary's or MAC's low-volume hospital status determination.

As we discussed in section V.C.2.b. of the preamble of this proposed rule, we are proposing to make conforming changes to the regulatory 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 FY 2013 made by section 605 of the ATRA. We are proposing changes to § 412.101 to conform the regulations to the statutory requirements that, beginning with FY 2014, the low-volume hospital qualifying criteria and payment adjustment methodology revert to that which was in effect prior to the amendments made by the Affordable Care Act and the ATRA (that is, the low-volume hospital payment adjustment policy in effect for FYs 2005 through 2010). Therefore, the low-volume hospital payment adjustment policy in effect prior for FYs 2005 through 2010 would apply for FY 2014 and subsequent years.

D. Indirect Medical Education (IME) Payment Adjustment (§ 412.105)

1. IME Adjustment Factor for FY 2014

Under the IPPS, an additional payment amount is made to hospitals that have residents in an approved graduate medical education (GME) program in order to reflect the higher indirect patient care costs of teaching hospitals relative to nonteaching hospitals. The payment amount is determined by use of a statutorily specified adjustment factor. The regulations regarding the calculation of this additional payment, known as the IME adjustment, are located at § 412.105. We refer readers to the FY 2012 IPPS/LTCH PPS final rule (76 FR 51680) for a full discussion of the IME adjustment and IME adjustment factor. Section 1886(d)(5)(B) of the Act states that, for discharges occurring during FY 2008 and fiscal years thereafter, the IME formula multiplier is 1.35. Accordingly, for discharges occurring during FY 2014, the formula multiplier is 1.35. We estimate that application of this formula multiplier for the FY 2014 IME adjustment will result in an increase in IPPS payment of 5.5 percent for every approximately 10 percent increase in the hospital's resident to bed ratio.

2. Other Proposed Policy Changes Affecting GME

In sections IV.J. of the preamble of this proposed rule, we present other proposed policy changes relating to GME payment. We refer readers to that section of the preamble of this proposed rule where we present the proposed policies.

E. Payment Adjustment for Medicare Disproportionate Share Hospitals (DSHs) (§ 412.106)

1. Background

Section 1886(d)(5)(F) of the Act provides for additional Medicare payments to subsection (d) hospitals that serve a significantly disproportionate number of low-income patients. The Act specifies two methods by which a hospital may qualify for the Medicare disproportionate share hospital (DSH) adjustment. Under the first method, hospitals that are located in an urban area and have 100 or more beds may receive a Medicare DSH payment adjustment if the hospital can demonstrate that, during its cost reporting period, more than 30 percent of its net inpatient care revenues are derived from State and local government payments for care furnished to needy patients with low incomes. This method is commonly referred to as the ''Pickle method.'' The second method for qualifying for the DSH payment adjustment, which is the most common, is based on a complex statutory formula under which the DSH payment adjustment is based on the hospital's geographic designation, the number of beds in the hospital, and the level of the hospital's disproportionate patient percentage (DPP). A hospital's DPP is the sum of two fractions: The ''Medicare fraction'' and the ''Medicaid fraction.'' The Medicare fraction (also known as the ''SSI fraction'' or ''SSI ratio'') is computed by dividing the number of the hospital's inpatient days that are furnished to patients who were entitled to both Medicare Part A and Supplemental Security Income (SSI) benefits by the hospital's total number of patient days furnished to patients entitled to benefits under Medicare Part A. The Medicaid fraction is computed by dividing the hospital's number of inpatient days furnished to patients who, for such days, were eligible for Medicaid, but were not entitled to benefits under Medicare Part A, by the hospital's total number of inpatient days in the same period.

Because the DSH payment adjustment is part of the IPPS, the DSH statutory references (under section 1886(d)(5)(F) of the Act) to ''days'' apply only to hospital acute care inpatient days. Regulations located at § 412.106 govern the Medicare DSH payment adjustment and specify how the DPP is calculated as well as how beds and patient days are counted in determining the Medicare DSH payment adjustment. Under § 412.106(a)(1)(i), the number of beds for the Medicare DSH payment adjustment is determined in accordance with bed counting rules for the IME adjustment under § 412.105(b).

2. Counting of Patient Days Associated With Patients Enrolled in Medicare Advantage Plans in the Medicare and Medicaid Fractions of the Disproportionate Patient Percentage (DPP) Calculation

The regulation at 42 CFR 422.2 defines Medicare Advantage (MA) plan to mean ''health benefits coverage offered under a policy or contract by an MA organization that includes a specific set of health benefits offered at a uniform premium and uniform level of cost-sharing to all Medicare beneficiaries residing in the service area of the MA plan . . . .'' Generally, each MA plan must at least provide coverage of all services that are covered by Medicare Part A and Part B, but also may provide for Medicare Part D benefits and/or additional supplemental benefits. However, certain items and services, such as hospice benefits, continue to be covered under Medicare fee-for-service (FFS). We note that, under § 422.50 of the regulations, an individual is eligible to elect an MA plan if he or she is entitled to Medicare Part A and enrolled in Medicare Part B. Dual eligible beneficiaries (individuals entitled to Medicare and eligible for Medicaid) also may choose to enroll in a MA plan, and, as an additional supplemental benefit, the MA plan may pay for Medicare cost-sharing not covered by Medicaid.

In the FY 2004 IPPS proposed rule (68 FR 27208) in response to questions about whether the patient days associated with patients enrolled in a Medicare + Choice (M+C) plan [now Medicare Advantage (MA) plan under Medicare Part C] should be counted in the Medicare fraction or the Medicaid fraction of the disproportionate patient percentage (DPP) calculation, we proposed that once a beneficiary enrolls in an M+C plan, those patient days attributable to the beneficiary would not be included in the Medicare fraction of the DPP. Instead, those patient days would be included in the numerator of the Medicaid fraction, if the patient also were eligible for Medicaid. In the FY 2004 IPPS final rule (68 FR 45422), we did not respond to public comments on this proposal, due to the volume and nature of the public comments we received, and we indicated that we would address those comments later in a separate document. In the FY 2005 IPPS proposed rule (69 FR 28286), we stated that we planned to address the FY 2004 comments regarding M+C days in the IPPS final rule for FY 2005. In the FY 2005 IPPS final rule (69 FR 49099), we determined that, under § 412.106(b)(2)(i) of the regulations, MA patient days should be counted in the Medicare fraction of the DPP calculation. We explained that, even where Medicare beneficiaries elect Medicare Part C coverage, they are still entitled to benefits under Medicare Part A. Therefore, we noted that if a Medicare M+C beneficiary is also an SSI recipient, the patient days for that beneficiary will be included in the numerator of the Medicare fraction (as well as in the denominator) and not in the numerator of the Medicaid fraction. We note that, despite our explicit statement in the final rule that the regulations also would be revised, due to a clerical error, the corresponding regulation at § 412.106(b)(2)(i) was not amended to explicitly reflect this policy until 2007 (72 FR 47384).

On November 15, 2012, in a ruling in the case of *Allina Health Services, et al.,* v. *Sebelius (Allina),* the Federal District Court for the District of Columbia (the court) held that the final policy of putting MA patient days in the Medicare fraction adopted in the FY 2005 IPPS final rule was not a logical outgrowth of the FY 2004 IPPS proposed rule. The court held that interested parties had not been put on notice that the Secretary might adopt a final policy of counting the days in the Medicare fraction and were not provided an adequate further opportunity for public comment.

We continue to believe that individuals enrolled in MA plans are ''entitled to benefits under part A'' as the phrase is used in the DSH provisions at section 1886(d)(5)(F)(vi)(I) of the Act. Section 226(a) of the Act provides that an individual is automatically ''entitled'' to Medicare Part A when the person reaches age 65 or becomes disabled, provided that the individual is entitled to Social Security benefits under section 202 of the Act. Beneficiaries who are enrolled in MA plans provided under Medicare Part C continue to meet all of the statutory criteria for entitlement to Medicare Part A benefits under section 226 of the Act. First, in order to enroll in Medicare Part C, a beneficiary must be ''entitled to benefits under Part A and enrolled under Part B'' (section 1852(a)(1)(B)(i) of the Act). There is nothing in the Act that suggests that beneficiaries who enroll in a Medicare Part C plan forfeit their entitlement to Medicare Part A benefits. Second, once a beneficiary enrolls in Medicare Part C, the MA plan must provide the beneficiary with the benefits to which he or she is entitled under Medicare Part A, even though it may also provide for additional supplemental benefits (section 1852(a)(1)(A) of the Act). Third, under certain circumstances, Medicare Part A pays for care furnished to patients enrolled in Medicare Part C plans. For example, if, during the course of the year, the scope of benefits provided under Medicare Part A expands beyond a certain cost threshold due to Congressional action or a national coverage determination, Medicare Part A will pay the provider for the cost of those services directly (section 1852(a)(5) of the Act). Similarly, Medicare Part A also pays for federally qualified health center services and hospice care furnished to MA patients (section 1853(a)(4) and (h)(2) of the Act, respectively). Thus, we continue to believe that a patient enrolled in an MA plan remains entitled to benefits under Medicare Part A, and should be counted in the Medicare fraction of the DPP, and not the Medicaid fraction.

We also believe that our policy of counting patients enrolled in MA plans in the Medicare fraction was a logical outgrowth of the FY 2004 IPPS proposed rule, and, accordingly, have filed an appeal in the *Allina* case. However, in an abundance of caution and for the reasons discussed above, in this proposed rule, we are proposing to readopt the policy of counting the days of patients enrolled in MA plans in the Medicare fraction of the DPP. We are seeking public comments from interested parties that may support or oppose the proposal to include the MA patient days in the Medicare fraction of the DPP calculation for FY 2014 and subsequent years. We will evaluate these public comments and consider whether a further change in policy is warranted, and will include our final determination in the FY 2014 IPPS final rule. We are not proposing any change to the regulation text at this time, because the current text reflects the policy being proposed.

3. New Payment Adjustment Methodology for Medicare Disproportionate Share Hospitals (DSHs) Under Section 3133 of the Affordable Care Act (§ 412.106)

a. General Discussion and Legislative Change

Section 3133 of the Patient Protection and Affordable Care Act (PPACA), as amended by section 10316 of PPACA and section 1104 of the Health Care and Education Reconciliation Act (Pub. L. 111–152), added a new section 1886(r) to the Act that modifies the methodology for computing the Medicare DSH payment adjustment beginning in FY 2014. For purposes of this proposed rule, we will refer to these

provisions collectively as Section 3133 of the Affordable Care Act.

Currently, Medicare DSH adjustment payments are calculated under a statutory formula that considers the hospital's Medicare utilization attributable to beneficiaries who also receive Supplemental Security Income (SSI) benefits and the hospital's Medicaid utilization. Beginning for discharges in FY 2014, hospitals that qualify for Medicare DSH payments under section 1886(d)(5)(F) will receive 25 percent of the amount they previously would have received under the current statutory formula for Medicare DSH payments. This provision applies equally to hospitals that qualify for DSH payments under section 1886(d)(5)(F)(i)(II) of the Act, the so-called Pickle hospitals. Pursuant to new section 1886(r), Pickle hospitals would receive 25 percent of the 35 percent add-on adjustment for which they would otherwise qualify under section 1886(d)(5)(F)(i)(II). The remaining amount, equal to an estimate of 75 percent of what otherwise would have been paid as Medicare DSH payments, reduced to reflect changes in the percentage of individuals under age 65 who are uninsured, will become available to make additional payments to each hospital that qualifies for Medicare DSH payments and that has uncompensated care. The payments to each hospital for a fiscal year will be based on the hospital's amount of uncompensated care for a given time period relative to the total amount of uncompensated care for that same time period reported by all hospitals that receive Medicare DSH payments for that fiscal year.

Specifically, as provided by section 3133 of the Affordable Care Act, section 1886(r) of the Act requires that, for ''fiscal year 2014 and each subsequent fiscal year,'' a ''subsection (d) hospital'' that would otherwise receive a ''disproportionate share hospital payment . . . made under subsection (d)(5)(F)'' will receive two separately calculated payments. Specifically, section 1886(r)(1) of the Act provides that the Secretary shall pay to such a subsection (d) hospital (including a Pickle hospital) 25 percent of the amount the hospital would have received under section 1886(d)(5)(F) of the Act for disproportionate share payments, which represents ''the empirically justified amount for such payment, as determined by the Medicare Payment Advisory Commission in its March 2007 Report to the Congress.'' We refer to this payment as the ''empirically justified Medicare DSH payment.''

In addition to this payment, section 1886(r)(2) of the Act provides that, for fiscal year 2014 and each subsequent fiscal year, the Secretary shall pay to ''such subsection (d) hospital an additional amount equal to the product of'' three factors. The first factor is the difference between ''the aggregate amount of payments that would be made to subsection (d) hospitals under subsection (d)(5)(F) if this subsection did not apply'' and ''the aggregate amount of payments that are made to subsection (d) hospitals under paragraph (1)'' for each fiscal year. Therefore, this factor amounts to 75 percent of the payments that would otherwise be made under section 1886(d)(5)(F) of the Act.

The second factor is, for FYs 2014 through 2017, 1 minus the percent change in the percent of individuals under the age of 65 who are uninsured, determined by comparing the percent of such individuals who are uninsured in 2013, the last year before coverage expansion under the Affordable Care Act (as calculated by the Secretary based on the most recent estimates available from the Director of the Congressional Budget Office before a vote in either House on the Health Care and Education Reconciliation Act of 2010 that, if determined in the affirmative, would clear such Act for enrollment), minus 0.1 percentage point for FY 2014, and minus 0.2 percentage point for FYs 2015 through 2017. For FYs 2014 through 2017, the baseline for the estimate of the change in uninsurance is fixed by the most recent estimate of the Congressional Budget Office before the final vote on the Health Care and Education Reconciliation Act of 2010, which is contained in a March 20, 2010 letter from the then Director of the Congressional Budget Office to the Speaker of the House. A link to this letter is included in section V.E.3.d.2. of the preamble of this proposed rule.

For FY 2018 and subsequent years, the second factor is 1 minus the percent change in the percent of individuals who are uninsured, as determined by comparing the percent of individuals ''who are uninsured in 2013 (as estimated by the Secretary, based on data from the Census Bureau or other sources the Secretary determines appropriate, and certified by the Chief Actuary'' of CMS, and ''who are uninsured in the most recent period for which data is available (as so estimated and certified) minus 0.2 percentage points for FYs 2018 and 2019.'' Thus, for FY 2018 and subsequent years, the statute provides some greater flexibility in the choice of the data sources to be used in the estimate of the change in the percent of the uninsured.

The third factor is a percent that, for each subsection (d) hospital, ''represents the quotient of . . . the amount of uncompensated care for such hospital for a period selected by the Secretary (as estimated by the Secretary, based on appropriate data . . .),'' including the use of alternative data ''where the Secretary determines that alternative data is available which is a better proxy for the costs of subsection (d) hospitals for . . . treating the uninsured,'' and ''the aggregate amount of uncompensated care for all subsection (d) hospitals that receive a payment under this subsection.'' Therefore, this third factor represents a hospital's uncompensated care amount for a given time period relative to the uncompensated care amount for that same time period for all hospitals that receive Medicare DSH payments in that fiscal year, expressed as a percent. For each hospital, the product of these three factors represents its additional payment for uncompensated care for the applicable fiscal year. We refer to the additional payment determined by these factors as the ''uncompensated care payment.''

Section 1886(r) of the Act states that this provision is effective for ''fiscal year 2014 and each subsequent fiscal year.'' In this proposed rule, we set forth our proposals for implementing the required changes to the DSH payment methodology. We note that, because section 1886 (r) modifies the payment required under section 1886(d)(5)(F) of the Act, it affects only the DSH payment under the operating IPPS. It does not revise or replace the capital IPPS DSH payment provided under the regulations at 42 CFR Part 412, Subpart M, which were established through the exercise of the Secretary's discretion in implementing the capital IPPS under section 1886(g)(1)(A) of the Act.

Finally, section 1886(r)(3) of the Act provides that there shall be ''no administrative or judicial review under section 1869, section 1878, or otherwise'' of ''any estimate of the Secretary for purposes of determining the factors described in paragraph (2),'' or of ''any period selected by the Secretary'' for the purpose of determining those factors. Therefore, there can be no administrative or judicial review of the estimates developed for purposes of applying the three factors used to determine uncompensated care payments, or the periods selected in order to develop such estimates.

b. Eligibility

As indicated above, the new payment methodology applies to ''subsection (d) hospitals'' that would otherwise receive a ''disproportionate share payment . . . made under subsection (d)(5)(F).'' Therefore, eligibility for empirically justified Medicare DSH payments is unchanged under this new provision. Consistent with the law, hospitals must receive empirically justified Medicare DSH payments in FY 2014 or a subsequent year to receive an additional Medicare uncompensated care payment for that year. Specifically, section 1886(r)(2) of the Act states that, ''[i]n addition to the payment made to a subsection (d) hospital under paragraph (1), . . . the Secretary shall pay to *such subsection (d) hospital* an additional amount . . .'' (Emphasis supplied.) Because paragraph (1) refers to empirically justified Medicare DSH payments, the additional payment under section 1886(r)(2) is, therefore, limited to hospitals that receive empirically justified Medicare DSH payments pursuant to section 1886(r)(1) of the Act for FY 2014 and subsequent years.

In this proposed rule, we are proposing that hospitals that are not eligible to receive empirically justified Medicare DSH payments in FY 2014 and subsequent years would not receive uncompensated care payments for those respective years. We also are proposing to make a determination concerning eligibility for interim uncompensated care payments based on each hospital's estimated DSH status for FY 2014 or the applicable year (using the most recent data that are available). Our final determination on the hospital's eligibility for uncompensated care payments would be based on the hospital's actual DSH status on the cost report for that payment year. (We discuss these proposals in more detail below.)

In the course of developing these proposed policies for implementing the provision of section 1886(r) of the Act, we considered whether several specific classes of hospitals are included within the scope of the statutory provision. In particular, we considered whether the provision applies to (1) hospitals in the Commonwealth of Puerto Rico, (2) hospitals in the State of Maryland paid under a waiver as provided in section 1814(b) of the Act, (3) sole community hospitals (SCHs), (4) hospitals participating in the Bundled Payments for Care Improvement Initiative developed by the Center for Medicare and Medicaid Innovation (Innovation Center), and (5) hospitals participating in the Rural Community Hospital demonstration. We discuss each of these specific classes of hospitals below.

(1) Puerto Rico Hospitals

Under section 1886(d)(9)(A) of the Act, Puerto Rico hospitals subject to the IPPS are not ''subsection (d) hospitals,'' but rather constitute a distinct class of ''subsection (d) Puerto Rico hospitals.'' However, section 1886(d)(9)(D)(iii) of the Act specifies that subparagraph (d)(5)(F) (the provision governing the current DSH payment methodology) ''shall apply to subsection (d) Puerto Rico hospitals . . . in the same manner and to the extent as [it applies] to subsection (d) hospitals.'' While the new section 1886(r) of the Act does not specifically address whether the methodology established there applies to ''subsection (d) Puerto Rico hospitals,'' section 3133 of the Affordable Care Act does make a revision to section 1886(d)(5)(F)(i) of the Act that is crucial for determining the eligibility of Puerto Rico hospitals for empirically justified Medicare DSH payments and uncompensated care payments under the new provision. Specifically, section 3133 of the Affordable Care Act amended section 1886(d)(5)(F)(i) of the Act to provide that this section is ''[s]ubject to subsection (r).'' One effect of this amendment is to provide that all hospitals subject to section 1886(d)(5)(F)(i) of the Act, including ''subsection (d) Puerto Rico hospitals,'' also are subject to the new payment methodology established in section 1886(r) of the Act.

In this proposed rule, we are proposing that subsection (d) Puerto Rico hospitals that are eligible for DSH payments also would be eligible to receive empirically justified Medicare DSH payments and uncompensated care payments under the new payment methodology.

We are inviting public comments on this proposal.

(2) Hospitals Paid Under a Waiver Under Section 1814(b) of the Act

Under section 1814(b) of the Act, hospitals in the State of Maryland are subject to a waiver from the Medicare payment methodologies under which they would otherwise be paid. We have taken the position in other contexts, for example, for purposes of EHR incentive payments (75 FR 44448), that Maryland acute care hospitals remain subsection (d) hospitals. This is because these hospitals are ''located in one of the fifty States or the District of Columbia'' (as provided in the definition of subsection (d) hospitals) and do not meet the definitions of the hospitals that are specifically excluded from that category, such as cancer hospitals and psychiatric hospitals. However, section 1886(r) of the Act applies to hospitals that are both subsection (d) hospitals and hospitals that would otherwise receive a disproportionate share payment made under the previous DSH payment methodology. Because Maryland waiver hospitals are paid under section 1814(b)(3) of the Act and not under section 1886(d)(5)(F) of the Act, they are not eligible to receive empirically justified Medicare DSH payments and uncompensated care payments under the new payment methodology of section 1886(r) of the Act.

(3) Sole Community Hospitals (SCHs)

SCHs are paid based on their hospital-specific rate from certain specified base years or the IPPS Federal rate, whichever yields the greatest aggregate payment for the hospital's cost reporting period. Payments based on the Federal rate are based on the IPPS standardized amount and include all applicable IPPS add-on payments, such as outliers, DSH, and IME, while payments based on the hospital-specific rate have no add-on payments. For each cost reporting period, the fiscal intermediary/MAC determines which of the payment options will yield the highest aggregate payment. Interim payments are automatically made on a claim-by-claim basis at the highest rate using the best data available at the time the fiscal intermediary/MAC makes the payment determination for each discharge. However, it may not be possible for the fiscal intermediary/MAC to determine in advance precisely which of the rates will yield the highest aggregate payment by year's end. In many instances, it is not possible to forecast outlier payments or the final amount of the DSH payment adjustment or the IME adjustment until cost report settlement. As noted above, these adjustment amounts are applicable only to payments based on the Federal rate and not to payments based on the hospital-specific rate. The fiscal intermediary/MAC makes a final adjustment at cost report settlement after it determines precisely which of the payment rates would yield the highest aggregate payment to the hospital for its cost reporting period. This payment methodology makes SCHs unique as they can change on a yearly basis from receiving hospital-specific rate payments to receiving Federal rate payments, or vice versa.

In order to implement the provisions of section 1886(r) of the Act, we are proposing to continue to determine interim payments for SCHs based on

what we estimate and project their DSH status to be prior to the beginning of the Federal fiscal year (based on the best available data at that time), subject to settlement through the cost report. We also are proposing that SCHs that receive interim empirically justified DSH payments in a fiscal year would receive interim uncompensated care payments that fiscal year, subject as well to settlement through the cost report. Final eligibility determinations would be made at the end of the cost reporting period at settlement, and both interim empirically justified Medicare DSH payments and uncompensated care payments would be adjusted accordingly. We are thus proposing to follow the same processes of interim and final payments for SCHs that we are proposing to follow for eligible IPPS DSH hospitals generally. (We discuss these processes in more detail below.)

As previously noted, under the SCH payment methodology, SCHs are paid the higher of the Federal rate or a hospital-specific payment rate. This payment methodology is defined under sections 1886(d)(5)(D)(i) and 1886(d)(1)(A)(iii) of the Act. Section 1886(d)(3) specifically provides that SCH payments are to be made on a per-discharge basis. Accordingly, as we also note below, we are proposing that the uncompensated care payments would not be accounted for in determining whether an SCH is paid the higher of the Federal rate or the hospital-specific rate. This is because the uncompensated care payments are not discharge-driven payments, but rather are payments made on the basis of a hospital's overall share of uncompensated care during a payment year. The amount of a hospital's uncompensated care payments for a year is not directly affected by the number of the hospital's discharges for the year. Therefore, we do not believe that uncompensated care payments should be taken into account in a comparison based on discharge driven hospital-specific and Federal rate payments. Furthermore, as we propose later in this rule, we intend to make interim uncompensated care payments on a periodic basis rather than a per discharge basis in order to create more predictability for hospitals and to increase administrative efficiency. To the extent the payments are intended to reflect the relative amount of uncompensated care furnished by the hospital, it is both reasonable and appropriate to view this payment as an amount for the year, which in the interests of predictability and consistency is made periodically through interim payments.

We are inviting public comments on all of these proposals affecting SCHs.

(4) Hospitals Participating in the Bundled Payments for Care Improvement Initiative

IPPS hospitals that have elected to participate in the Bundled Payments for Care Improvement initiative receive a payment that links multiple services furnished to a patient during an episode of care. We have stated in previous rulemaking that those hospitals continue to be paid under the IPPS (77 FR 53342). Hospitals that elect to participate in the initiative can still receive DSH payments while participating in the initiative, if they otherwise meet the requirements for receiving such payments.

In this proposed rule, we are proposing to apply the new DSH payment methodology to the hospitals in this initiative, so that eligible hospitals would receive empirically justified DSH payments and uncompensated care payments.

We are inviting public comments on this proposal.

(5) Hospitals Participating in the Rural Community Hospital Demonstration

Section 410A of the Medicare Modernization Act established the Rural Community Hospital Demonstration Program. After the initial 5-year period, the demonstration was extended for an additional 5-year period by sections 3123 and 10313 of the Affordable Care Act. There are 23 hospitals currently participating in the demonstration. Under the payment methodology provided in section 410A, participating hospitals receive payment for Medicare inpatient services on the basis of a cost methodology. Specifically, for discharges occurring in the hospitals' first cost reporting period of the initial 5-year demonstration or the first cost reporting period of the 5-year extension, they receive payments for the reasonable cost of providing such services. For discharges occurring in subsequent cost reporting periods during the applicable 5-year demonstration period, hospitals receive the lesser of the current year's reasonable cost amount, or the previous year's amount updated by the percentage increase in the IPPS market basket (the target amount). (We refer readers to section V.K. of the preamble of this proposed rule for further information on the demonstration.) The instructions (CR 5020 (April 14, 2006) and CR 7505 (July 22, 2011)) for the demonstration require that the fiscal intermediary/MAC not pay Medicare DSH payments in addition to the amount received under the cost-based payment methodology. Although the amounts that would otherwise be paid for Medicare DSH payments (absent the demonstration) are calculated and identified on the hospital cost report for statistical and research purposes, as in the case of Maryland waiver hospitals, hospitals in this demonstration do not receive a separate or identifiable DSH payment.

Because hospitals participating in the Rural Community Hospital Demonstration do not receive DSH payments, these hospitals are also excluded from receiving empirically justified Medicare DSH payments and uncompensated care payments under the new payment methodology.

c. Empirically Justified Medicare DSH Payments

As we have discussed above, the statute requires CMS to pay 25 percent of the ''amount of disproportionate share hospital payment that would otherwise be made under subsection (d)(5)(F) to a subsection (d) hospital.'' Currently, we have a system for interim payment and final settlement of DSH payments made under section 1886(d)(5)(F). Specifically, interim payments are made for each claim based on the best available data concerning each hospital's eligibility for DSH payments and the appropriate level of such payments. Final eligibility for Medicare DSH payments and the final amount of such payments for eligible hospitals are determined at the time of cost report settlement. Because section 1886(r)(1) of the Act merely requires the program to pay a designated percentage of these payments, without revising the criteria governing eligibility for DSH payments or the underlying payment methodology, we do not believe that it is necessary to develop and propose any new operational mechanisms for making such payments.

Therefore, we are proposing to implement this provision simply by revising the claims payment methodologies to adjust the interim claim payments to the requisite 25 percent of what would have otherwise been paid. We will also make corresponding changes to the hospital cost report so that these empirically justified Medicare DSH payments can be settled at the appropriate level at the time of cost report settlement. We will provide more detailed operational instructions and cost report instructions following issuance of the final rule.

We are proposing to implement this provision by adding a new paragraph (f) under the regulations at 42 CFR 412.106. This proposed new paragraph

provides for reducing Medicare DSH payments by 75 percent beginning in FY 2014.

We are inviting public comments on this proposal.

d. Uncompensated Care Payments

As we have discussed above, section 1886(r)(2) of the Act provides that, for each eligible hospital in FY 2014 and subsequent years, the new uncompensated care payment is the product of three factors. These three factors represent our estimate of 75 percent of the amount of Medicare DSH payments that would otherwise have been paid, an adjustment to this amount for the percent change in the national rate of uninsurance compared to a base of 2013, and each eligible hospital's estimated uncompensated care amount relative to the estimated uncompensated care amount for all eligible hospitals. Below we discuss the proposed data sources and methodologies for computing each of these factors.

Before we begin to discuss these data sources and methodologies, it is necessary to discuss the timing and manner for determining the eligibility of hospitals for uncompensated care payments. The statute provides that subsection (d) hospitals that receive a payment under section 1886(d)(5)(F) of the Act are eligible to receive a payment under section 1886(r)(2) of the Act. Specifically, section 1886(r)(2) of the Act states that, ''[i]n addition to the payment made to a subsection (d) hospital under paragraph (1) . . . the Secretary shall pay to such subsection (d) hospitals an additional amount. . . .'' Therefore, because paragraph (1) refers to empirically justified Medicare DSH payments, the additional payment for FY 2014 and subsequent years is limited to hospitals that receive empirically justified Medicare DSH payments for the respective year. However, as we have discussed above, we currently have a system for interim payment and final settlement of DSH payments. Specifically, interim payments are made for each claim based on the best available data concerning each hospital's eligibility for DSH payments and the appropriate level of such payments. Final determination of eligibility for Medicare DSH payments and the final amount of such payments for eligible hospitals are determined at the time of cost report settlement.

As we describe above, because section 1886(r)(1) of the Act does not revise the criteria governing eligibility for DSH payments or the underlying payment methodology, we do not believe that it is necessary to develop and propose any new operational mechanisms for making such payments and would thus continue using the existing system of interim eligibility and payment determination with final cost report settlement for the empirically justified Medicare DSH payments. We are proposing to adopt a similar system of interim eligibility and payment determination with final cost report settlement for purposes of uncompensated care payments. We discuss the specific operational details of this system in section V.E.3.f. of this preamble.

We are inviting public comments on these proposals.

(1) Proposed Methodology To Calculate Factor 1

Section 1886(r)(2)(A) of the Act establishes Factor 1 in the calculation of the uncompensated care payment. Section 1886(r)(2)(A) of the Act states that it is a factor ''equal to the difference between (i) the aggregate amount of payments that would be made to subsection (d) hospitals under subsection (d)(5)(F) if this subsection did not apply for such fiscal year (as estimated by the Secretary); and (ii) the aggregate amount of payments that are made to subsection (d) hospitals under paragraph (1) for such a fiscal year (as so estimated).'' Therefore, section 1886(r)(2)(A)(i) of the Act represents the estimated Medicare DSH payment that would have been made if the reduction to the Medicare DSH payment by 75 percent under section 1886(r)(1) of the Act did not apply for such fiscal year. In other words, section 1886(r)(2)(A)(i) of the Act represents an estimate of the full Medicare DSH payment amount under section 1886(d)(5)(F) prior to the 75-percent reduction, for FY 2014 and subsequent years. This subparagraph specifies that, for each fiscal year to which the provision applies, such amount is to be ''estimated by the Secretary.'' Under a prospective payment system, we would not know the precise aggregate Medicare DSH payment amount that would be paid for a Federal fiscal year until cost report settlement for all IPPS hospitals is completed, which occurs several years after the end of the Federal fiscal year. Therefore, the statute gives CMS authority to estimate this amount, by specifying that, for each fiscal year to which the provision applies, such amount is to be ''estimated by the Secretary.'' Similarly, section 1886(r)(2)(A)(ii) of the Act represents the estimated empirically justified Medicare DSH payments to be made in FY 2014 and subsequent years, taking into account the application of the 75 percent reduction to the DSH payment amounts prescribed under section 1886(r)(1) of the Act. Again, section 1886(r)(2)(A)(ii) of the Act gives CMS authority to estimate this amount.

Therefore, Factor 1 is the difference between our estimates of: (1) The amount that would have been paid in Medicare DSH payments for FY 2014 and subsequent years, in the absence of the new payment provision; and (2) the amount of empirically justified Medicare DSH payments that are made for FY 2014 and subsequent years, which takes into account the requirement to reduce Medicare DSH payments by 75 percent. In other words, this factor represents our estimate of 75 percent (100 percent minus 25 percent) of our estimate of Medicare DSH payments that would otherwise be made, in the absence of section 1886(r) of the Act, for FY 2014 and subsequent years.

In order to determine Factor 1 in the uncompensated care payment formula, we are proposing to develop final estimates of both the aggregate amount of Medicare DSH payments that would be made in the absence of section 1886(r)(1) and the aggregate amount of empirically justified Medicare DSH payments to hospitals under section 1886(r)(1) prior to each fiscal year to which the new provision applies. We believe this will create some level of predictability and finality for hospitals eligible for these payments, in addition to being administratively efficient. Specifically, in order to determine the two elements of Factor 1 (Medicare DSH payments prior to the application of the 75 percent reduction, and empirically justified Medicare DSH payments after application of the 75 percent reduction), we are proposing to use the most recently available projections of Medicare DSH payments for FY 2014 and each subsequent year, as calculated by CMS' Office of the Actuary. The Office of the Actuary projects Medicare DSH payments on a biannual basis, typically in February of each year (based on data from December of the previous year) as part of the President's Budget, and in July (based on data from June) as part of the Midsession Review. The estimates are based on the most recently filed Medicare hospital cost report with Medicare DSH payment information and the most recent Medicare DSH patient percentages and Medicare DSH payment adjustments provided in the IPPS Impact File.

Therefore, for the Office of the Actuary's February 2013 estimate, the data are based on the December 2012 update of the Medicare Hospital Cost Report Information System (HCRIS) and

the FY 2013 IPPS/LTCH PPS final rule IPPS Impact file, published in conjunction with the publication of the FY 2013 IPPS/LTCH PPS final rule. For the July 2013 estimate, we anticipate that the data will be based on the March 2013 update of the Medicare Hospital Cost Report data and this proposed rule's IPPS Impact file, published in conjunction with this proposed rule. For purposes of this proposed rule, we are using the February 2013 Medicare DSH estimates to calculate Factor 1 and to model the proposed impact of this provision. If our proposal to use the Office of the Actuary's projections for Factor 1 is finalized, we would use the July 2013 Medicare DSH estimates to determine Factor 1 for the FY 2014 IPPS/LTCH PPS final rule.

In addition, because we are proposing to exclude sole community hospitals paid under their hospital specific payment rate from the application of section 1886(r) of the Act, we are also proposing to exclude these hospitals from our Medicare DSH estimate. Similarly, because Maryland hospitals and hospitals participating in the Rural Community Hospital Demonstration do not receive DSH payments, we also exclude these hospitals from our Medicare DSH estimate.

Using the data sources discussed above, the Office of the Actuary uses the most recently submitted Medicare cost report data to identify current Medicare DSH payments and the most recent DSH payment adjustments provided in the IPPS Impact File, and applies inflation updates and assumptions for future changes in utilization and case mix to estimate Medicare DSH payments for the upcoming fiscal year. The February 2013 Office of the Actuary estimate for Medicare DSH payments for FY 2014, without regard to the application of section 1886(r)(1) of the Act, is 12.338 billion. This estimate excludes Maryland hospitals, sole community hospitals paid under their hospital specific payment rate and hospitals participating in the Rural Community Hospital Demonstration as discussed above. Therefore, based on this estimate, the estimate for empirically justified Medicare DSH payments for FY 2014, with the application of section 1886(r)(1) of the Act, is $3.084 billion (25 percent of the total amount estimated). Under our proposal, Factor 1 is the difference of these two estimates of the Office of the Actuary. Therefore, for the purpose of modeling Factor 1, we calculate Factor 1 to be $9.2535 billion.

We also are proposing to develop and use the estimates necessary for Factor 1 on a purely prospective basis. We are proposing to use the Actuary's most recent February Medicare DSH estimates each year to calculate Factor 1 and to model the impact of this provision for the IPPS/LTCH PPS proposed rule. Similarly, we are proposing to use the Actuary's most recent July Medicare DSH estimates to determine Factor 1 for the IPPS/LTCH PPS final rule each year. In other words, we would not revise or update our estimates after we know the final Medicare DSH payments for FY 2014 and subsequent years. As we discussed earlier, we do not know the aggregate Medicare DSH payment amount that would be paid for each federal fiscal year until the time of cost report settlements, which occur several years after the end of the fiscal year. Because the statute provides that CMS use estimates in order to determine Factor 1 each year, we believe that applying our best estimates prospectively would be most conducive to administrative efficiency, finality, and predictability in payments.

We are inviting public comments on all the elements of this proposed methodology to calculate Factor 1.

We are proposing to add a new paragraph (g)(1)(i) under § 412.106 of our regulations to define the methodology for calculating Factor 1.

(2) Proposed Methodology To Calculate Factor 2

Section 1886(r)(2)(B) of the Act establishes Factor 2 in the calculation of the uncompensated care payment. Specifically, section 1886(r)(2)(B)(i) of the Act provides: ''For each of fiscal years 2014, 2015, 2016, and 2017, a factor equal to 1 minus the percent change in the percent of individuals under the age of 65 who are uninsured, as determined by comparing the percent of such individuals (I) who are uninsured in 2013, the last year before coverage expansion under the Patient Protection and Affordable Care Act (as calculated by the Secretary based on the most recent estimates available from the Director of the Congressional Budget Office before a vote in either House on the Health Care and Education Reconciliation Act of 2010 that, if determined in the affirmative, would clear such Act for enrollment); and (II) who are uninsured in the most recent period for which data is available (as so calculated), minus 0.1 percentage points for fiscal year 2014 and minus 0.2 percentage points for each of fiscal years 2015, 2016, and 2017.''

Section 1886(r)(2)(B) of the Act establishes, as Factor 2 in the uncompensated care payment formula, the percent change in uninsurance, based on a comparison of the percent of individuals under 65 without insurance in 2013 to the percent of such individuals without insurance in the most recent period for which we have data, minus 0.1 percentage points for FY 2014 and 0.2 percentage points for each of FYs 2015, 2016, and 2017.

Section 1886(r)(2)(B)(i)(I) of the Act further indicates that the percent of individuals under 65 without insurance in 2013 must be the percent of such individuals ''who are uninsured in 2013, the last year before coverage expansion under the Patient Protection and Affordable Care Act (as calculated by the Secretary based on the most recent estimates available from the Director of the Congressional Budget Office before a vote in either House on the Health Care and Education Reconciliation Act of 2010 that, if determined in the affirmative, would clear such Act for enrollment).'' The Health Care and Education Reconciliation Act (Pub. L. 111–152) was enacted on March 30, 2010. It was passed in the House of Representatives on March 21, 2010 and by the Senate on March 25, 2010. Because the House of Representatives was the first House to vote on the Health Care and Education Reconciliation Act of 2010 on March 21, 2010, we have determined that the most recent estimate available from the Director of the Congressional Budget Office ''*before* a vote in either House on the Health Care and Education Reconciliation Act of 2010 . . .'' appeared in a March 20, 2010 letter from the director of the CBO to the Speaker of the House. (Emphasis supplied.) Therefore, we believe that only the estimates in this March 20, 2010 letter meet the statutory requirement under section 1886(r)(2)(B)(i)(I). (To view the March 20, 2010 letter, we refer readers to the Web site at: *http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/113xx/doc11379/amendreconprop.pdf*.

In its March 20, 2010 CBO letter to the Speaker of the House, the CBO provides two estimates of the ''post-policy uninsured population.'' The first estimate is of the ''Insured Share of the Nonelderly Population Including All Residents'' (which is 82 percent) and the second estimate is of the ''Insured Share of the Nonelderly Population Excluding Unauthorized Immigrants'' (83 percent). We are proposing to use the first estimate that includes all residents, including unauthorized immigrants. We believe this estimate is most consistent with the statute which requires us to measure ''the percent of individuals under the age of 65 who are uninsured,'' and provides no exclusions except for individuals over the age 65.

In addition, we believe that this estimate would more fully reflect the levels of uninsurance in the United States that influence uncompensated care for hospitals. Therefore, using this estimate would seem more consistent with the statutory requirement of establishing a payment for uncompensated care. For these reasons, we are proposing to use the estimate of the ''Insured Share of the Nonelderly Population Including All Residents'' for 2013 to calculate the baseline percentage of individuals under age 65 without insurance.

We are inviting public comments on this proposal.

The March 20, 2010 CBO letter reports these figures as the estimated percentage of individuals with insurance. However, because section 1886(r)(2)(B)(i) of the Act requires that we compare the percent of individuals ''who are uninsured in 2013,'' we are proposing to use the CBO insurance rate figure and subtract that amount from 100 percent (i.e., the total population, without regard to insurance status) to estimate the 2013 baseline percentage of individuals without insurance. In its March 20, 2010 letter, the CBO reported its estimate of the ''Insured Share of the Nonelderly Population Including All Residents'' as 82 percent. Therefore, we are proposing that, for FYs 2014–2017, our estimate of the uninsurance percentage for 2013 would be 18 percent. As provided for in the CBO March 20, 2010 letter, the CBO estimate for insurance for the nonelderly (under age of 65) population only includes residents of the 50 States and the District of Columbia, and the count of uninsured people includes unauthorized immigrants, as well as people who are eligible for, but not enrolled in, Medicaid. We note that, although we are proposing that acute care hospitals located in Puerto Rico that receive DSH payments will be eligible to receive payments under section 1886(r) of the Act, this estimate for insurance does not account for residents in Puerto Rico. We believe that the impact of the exclusion of Puerto Rico from the insurance estimate is negligible.

We are inviting public comments on this proposal.

Section 1886(r)(2)(B)(i) of the Act requires that we compare the baseline uninsurance rate to the percent of such individuals ''who are uninsured in the most recent period for which data is available (as so calculated).'' We are proposing to use the same data source, CBO estimates, to calculate this percent of individuals without insurance. Section 1886(r)(2)(B)(i)(I) of the Act refers to the percent of uninsured in 2013 ''as calculated by the Secretary based on'' the CBO data. Similarly, section 1886(r)(2)(B)(i)(II) of the Act immediately afterwards refers to the percent of uninsured for 2014 ''as *so* calculated.'' (Emphasis supplied.) The phrase ''as so calculated'' in the latter section can be reasonably interpreted to require the calculation to similarly be based on CBO estimates. In addition, we believe that it is preferable from a statistical point of view to calculate a percent change in insurance over time using a consistent data source. Furthermore, rather than using the estimates included in the March 20, 2010 CBO letter, we believe it is appropriate to use more recent CBO estimates of the percent of individuals with insurance. The more recent CBO projections take into account changes in the environment that can impact insurance rates, such as more recent economic conditions and the Supreme Court's decision in *National Federation of Independent Business.* v. *Sebelius,* ___ U.S. ___, 132 S. Ct. 2566 (2012), regarding Medicaid expansions authorized by the Affordable Care Act. Because the statute requires that we use ''the most recent period for which data is available'' to calculate the comparison percentage of individuals without insurance, we are proposing to use the most recent update (that is, the most recent update available at the time of rulemaking with respect to a particular fiscal year) to the percent of individuals with insurance provided by the CBO to calculate this comparison figure.

In addition, for FY 2014, we are proposing to use CBO's most recent estimate for the percent of individuals with insurance in 2014 for purposes of section 1886(r)(2)(B)(i)(II) because this is the year in which this provision is effective. This figure is used for Factor 2 and later applied to Factor 1, which is also based on an estimate for FY 2014. On February 5, 2013, the CBO released its annual *Budget and Economic Outlook.* The report included updated economic and budget projections that incorporated the effects of the legislation enacted prior to the start of the year, a revised economic forecast consistent with the budget projections, and other changes to CBO's estimates. (To view the report, we refer readers to the Web site at: *http://www.cbo.gov/sites/default/files/cbofiles/attachments/43900_ACAInsuranceCoverageEffects.pdf.*)

In this proposed rule, we are using the February 5, 2013, CBO health insurance estimates in order to calculate the percentage of individuals without insurance for 2014. As we did for the uninsurance percentage estimate for 2013 (based on the March 20, 2010 CBO letter discussed above), we are proposing to use the ''Insured Share of the Nonelderly Population Including All Residents'' to calculate the comparison of percentage of people without insurance for 2014. Consistent with the CBO estimate used to calculate the baseline uninsurance estimate, this estimate for insurance only includes residents of the 50 States and the District of Columbia, and the count of uninsured people includes unauthorized immigrants, as well as people who are eligible for, but not enrolled in, Medicaid. The CBO report projects that the ''Insured Share of the Nonelderly Population Including All Residents'' for 2014 will be 84 percent. Therefore, in the same manner that we calculated the uninsurance percentage for the baseline, we are proposing that the uninsurance percentage for 2014 would be 16 percent (i.e., 100 percent minus 84 percent) for the purpose of this proposed rule. If our proposal is finalized, and there is a more recent estimate of the percentage of individuals with insurance in 2014 by the CBO available for the FY 2014 IPPS/LTCH PPS final rule, we would use that estimate to calculate Factor 2. However, we would not adjust Factor 2 retroactively to account for estimates that become available after publication of the final rule.

Section 1886(r)(2)(B)(i) of the Act states that Factor 2 for FY 2014 is equal to 1 minus the percent change in the percent of individuals under the age of 65 who are uninsured, as determined by comparing the percent of such individuals without insurance in the baseline and in the most recent period for which we have data (minus 0.1 percentage points for FY 2014). Therefore, we are proposing that Factor 2 is 1 minus the percent change of the baseline percentage of individuals without insurance in 2013 (which is, for this proposed rule, 18 percent) and the most recent percentage of individuals without insurance for 2014 (which is, for this proposed rule, 16 percent) minus 0.1 percentage points.

Using the March 20, 2010 CBO projection for 2013 and the February 5, 2013 CBO projection of uninsurance for all residents for 2014, we are proposing to use the following computation for Factor 2 for FY 2014:

Percent of individuals without insurance for 2013: 18 percent

Percent of individuals without insurance for 2014: 16 percent

$1 - |[(0.16 - 0.18)/0.18]| = 1 - 0.111 = 0.889$ (88.9 percent)

0.889 (88.9 percent) − 0.001 (0.1 percentage points) = 0.888 (88.8 percent)
0.888 = Factor 2

Accordingly, we are proposing Factor 2 to be 88.8 percent for FY 2014. In conjunction with this proposal, we are therefore proposing that the amount available for uncompensated care payments for FY 2014 will be $8.217 billion (0.888 times our proposed Factor 1 estimate of $9.2535 billion). As we noted previously, our proposal for Factor 2 may be subject to change if more recent CBO estimates of the insurance rate for 2014 become available prior to the preparation of the final rule.

We are inviting public comment on our proposed methodology to calculate Factor 2.

In this proposed rule, we are proposing to add a new paragraph (g)(1)(ii) under § 412.106 of our regulations to define the methodology for calculating Factor 2.

(3) Proposed Methodology To Calculate Factor 3

Section 1886(r)(2)(C) of the Act defines Factor 3 in the calculation of the uncompensated care payment. As we have discussed above, section 1886(r)(2)(C) of the Act states that Factor 3 is ''equal to the percent, for each subsection (d) hospital, that represents the quotient of (i) the amount of uncompensated care for such hospital for a period selected by the Secretary (as estimated by the Secretary, based on appropriate data (including, in the case where the Secretary determines alternative data is available which is a better proxy for the costs of subsection (d) hospitals for treating the uninsured, the use of such alternative data)); and (ii) the aggregate amount of uncompensated care for all subsection (d) hospitals that receive a payment under this subsection for such period (as so estimated, based on such data).''

Therefore, Factor 3 is a hospital-specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital and subsection (d) Puerto Rico hospital with the potential to receive DSH payments relative to the estimated uncompensated care amount for all hospitals estimated to receive DSH payments in the fiscal year for which the uncompensated care payment is to be made. Factor 3 is applied to the product of Factor 1 and Factor 2 to determine the amount of the uncompensated care payment that each eligible hospital will receive for FY 2014 and subsequent years. In order to implement the statutory requirements for this factor of the uncompensated care payment formula, we must determine the following: (1) The definition of uncompensated care, or in other words, the specific items that are to be included in the numerator (that is, the estimated uncompensated care amount for an individual hospital) and denominator (that is, the estimated uncompensated care amount for all hospitals estimated to receive DSH payments in the applicable FY); (2) the data source(s) for the estimated uncompensated care amount; and (3) the timing and manner of computing the quotient for each hospital estimated to receive DSH payments. The statute instructs the Secretary to estimate the amounts of uncompensated care for a period ''based on appropriate data.'' In addition, we note that the statute permits the Secretary to use alternative data ''in the case where the Secretary determines that alternative data is available, which is a better proxy for the costs of subsection (d) hospitals for treating the uninsured.

In the course of considering how to determine Factor 3, we considered proposing to define the amount uncompensated care for a hospital as the uncompensated care costs of that hospital and considered potential data sources for those costs. In doing so, we first considered which costs should be included in the definition of ''uncompensated care costs.'' We examined the broad literature on uncompensated care and the concepts of uncompensated care used in various public and private programs. We also considered input from stakeholders and public comments in various forums, including the national provider call that we held in January 2013. Our review of the information from these sources indicated that there is some variation in how different States, provider organizations, and Federal programs define ''uncompensated care.'' However, a common theme of almost all these definitions is that they include both ''charity care'' and ''bad debt'' as constituents of ''uncompensated care.'' After considering the various factors that are included in different definitions of ''uncompensated care,'' we considered proposing to adopt a definition which incorporated those factors that are most commonly included within the term. Thus we considered proposing to define ''uncompensated care'' as the cost of charity care plus bad debt which includes the cost of non-Medicare bad debt and non-reimbursed Medicare bad debt. In turn, we also considered proposing to define ''charity care costs'' as the cost of care for patients that meet hospitals' individual criteria for charity care net of any partial payment received by the hospital from patients for that care, and to define ''non-Medicare bad debt costs'' as the cost of hospital care for non-Medicare patients that have the financial capacity to pay, but are unwilling to settle the claim. In addition, we considered proposing to define ''non-reimbursed Medicare bad debt costs'' as the amount of allowable coinsurance and deductible for Medicare patients from whom the hospital has sought to collect payment through reasonable collection efforts as described in § 413.89(e) of the Medicare regulations and not reimbursed by Medicare.

Charity care is most commonly defined as hospital care provided to individuals that meet certain financial eligibility criteria, for which the hospital does not expect to receive payment because of the individual's inability to pay. Definitions of charity care also regularly state that a patient must meet several guidelines for their care to qualify as charity care. These guidelines usually state that the patient must be uninsured, unqualified for a Federal program such as Medicaid, and/or fall under a certain Federal poverty line (FPL) standard. Some charity care is directed at insured individuals when insurance does not cover all the costs of their hospital care or when there are annual or lifetime limits. This definition also varies by hospital. Some hospitals may also seek payment from individuals who qualify for charity care as part of their financial assistance policies or to help offset the cost of that patient's hospital care. To the extent that hospitals receive payment from a patient that qualifies for charity care for hospital care provided, we believe that those payments should be subtracted from the costs of that care. In this way, the cost of charity care reflects the financial burden on the hospital, or, stated another way, the cost of charity care reflects only the uncompensated portion of the charity care.

The literature suggests that bad debt has been consistently defined as unreimbursed care for persons for which the hospital did not receive payment. The regulations at 42 CFR 413.89(b)(1) define Medicare bad debt as ''amounts considered to be uncollectible from accounts and notes receivable that were created or acquired in providing services.'' The regulations also specify that: '''accounts receivable' and 'notes receivable' are designations for claims arising from the furnishing of services, and are collectible in money in the relatively near future.'' Section 413.89(e) further specifies that under

Medicare ''bad debt must meet the following criteria to be allowable: (1) The debt must be related to covered services and derived from deductible and coinsurance amounts. (2) The provider must be able to establish that reasonable collection efforts were made. (3) The debt was actually uncollectible when claimed as worthless. (4) Sound business judgment established that there was no likelihood of recovery at any time in the future. We considered proposing to use the cost of non-Medicare and non-reimbursed Medicare bad debt (as reported on line 29 of the Worksheet S–10) as part of the proposed definition of ''uncompensated care.''

Some definitions of uncompensated care, including that used for calculating the Medicaid DSH hospital payment limit at 42 CFR 447.299(c)(16), also include the difference between the costs incurred by a hospital for services to Medicaid individuals and applicable revenues for these services. While we recognize in some cases, a hospital may receive revenues that do not fully cover those costs, we note that this is true for any patient population treated by a hospital regardless of insurance status. Hospitals negotiate contractual allowances with commercial payers, and it is possible that payment for some of these patients would be less than the costs of their care.

We emphasize, however, that we plan to monitor the potential effects of different definitions of uncompensated care on various measures designed to expand health insurance coverage under the Affordable Care Act, including Medicaid expansion.

Specifically, we wish to avoid creating a policy that would serve as a disincentive for States wishing to expand Medicaid. Using some of the data discussed in this proposed rule, we recognize it would be possible for hospitals in States that choose to expand Medicaid to receive lower uncompensated care payments because they are less likely to have uninsured patients than hospitals in a State that does not choose to expand Medicaid. In practice, because the available data sources (such as the Medicare cost report) for a given federal fiscal year are not available until some time after the end of that federal fiscal year, we believe that data to understand these effects will not be available until 2016 or later. However, we also note that hospitals in expansion States would receive full Medicaid reimbursement for many previously uninsured patients. So on balance, we believe both hospitals and States stand to benefit greatly from Medicaid expansion, regardless of the data used to determine Factor 3. However, if warranted, we may in the future reconsider how to define uncompensated care, such as to include differences between applicable Medicaid costs and revenues, or consider other definitions that would account for differences in State Medicaid coverage.

For purposes of selecting an appropriate data source for this possible definition of uncompensated care costs, we reviewed the literature and available data sources and determined that the Medicare cost report Worksheet S–10 could potentially provide the most complete data for Medicare hospitals. (We refer readers to the report ''Improvements to Medicare Disproportionate Share (DSH) Payments'' for a full discussion and evaluation of the available data sources. The report can be found on the CMS Web site at: *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.html*.) However, Worksheet S–10 is a relatively new data source that has been used for specific payment purposes only in relatively restricted ways (e.g., to provide a source of charity care charges in the computation of EHR incentive payments; 75 FR 44456.). Some stakeholders have expressed concern that hospitals have not had enough time to learn how to submit accurate and consistent data through this reporting mechanism. Other stakeholders have maintained that some instructions for Worksheet S–10 still require clarification in order to ensure standardized and consistent reporting by hospitals. We understand and appreciate the concerns of these stakeholders. At the same time, Worksheet S–10 is the only national data source that includes data for all Medicare hospitals and is designed to elicit data that are both accurate and consistent with the definition of uncompensated care costs that we considered proposing to use.

Charity care information is reported on Worksheet S–10, lines 20 through 23. On line 20, Column 3, hospitals report ''Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility'' for both the insured and uninsured population. On Worksheet S–10, line 21, the charity care charges reported on line 20 are converted to charity care costs by multiplying the charity care charges by the cost-to-charge ratio (CCR) reported on line 1 of Worksheet S–10. Partial payment by patients for charity care is reported on line 22 of Worksheet S–10. Charity care costs are reported on line 23 of Worksheet S–10 as the difference between line 21 and 22. We could use ''Cost of Charity Care,'' line 23, Column 3 of Worksheet S–10 to identify a hospital's charity care costs, as part of a definition of ''uncompensated care.''

Bad debt information is reported on Worksheet S–10, lines 26 through 29. On Worksheet S–10, line 26 and line 27, a hospital reports its total bad debt expense and its Medicare reimbursed bad debt expense, respectively. On Worksheet S–10, line 28 represents the non-Medicare bad debt expense and non-reimbursed Medicare bad debt expense, the difference between lines 27 and 26. The cost of non-Medicare bad debt and non-reimbursed Medicare is reported on line 29 of the Worksheet S–10 as the product of the CCR and the non-Medicare and non-reimbursed Medicare bad debt expense reported on line 28. We could use the cost of non-Medicare bad debt and non-reimbursed Medicare that is reported on line 29 of the Worksheet S–10 to identify a hospital's bad debt costs, as part of a definition of ''uncompensated care.''

To summarize, we could use the sum of line 23, Column 3 of Worksheet S–10 and line 29 of Worksheet S–10 to estimate a hospital's uncompensated care cost. A hospital's individual uncompensated care cost based on this estimate would represent that hospital's numerator for Factor 3. The sum of the estimated uncompensated care costs for all the hospitals that we estimate would receive DSH payments (and thus the uncompensated care payment) for the fiscal year would represent the denominator of Factor 3.

In order to apply a definition of uncompensated care costs based upon information reported on the Worksheet S–10, it would be necessary to use the 2010/2011 cost reports, which were submitted on or after May 1, 2010, when the new Worksheet S–10 went into effect. These are the most recently available full year of cost reports and the first cost reports with detailed uncompensated care data on the Worksheet S–10 that would be available for use in implementing the new methodology for uncompensated care payments for FY 2014. Concerns about the standardization and completeness of the Worksheet S–10 data could be more acute for data collected in the first year of the Worksheet's use. Because of these concerns, we are not proposing to define of uncompensated care in a way that would require use of the Worksheet S–10 data.

We believe, however, that Worksheet S–10 of the Medicare Cost Report would otherwise be an appropriate data source to determine uncompensated care costs. In particular, we note that Worksheet S–

10 was developed specifically to collect information on uncompensated care costs in response to interest by MedPAC and other stakeholders regarding the topic (for example, MedPAC's March 2007 Report to Congress) and that it is not unreasonable to expect information on the cost report to be used for payment purposes. Furthermore, hospitals attest to the accuracy and completeness of the information reported in the cost report at the time of submission. While we realize that hospitals may wish to have a more specific understanding of how this data will be used, we believe that the discussion in this proposed rule will help to increase their understanding and also inform our efforts to refine the cost report and cost report instructions so that hospitals may continue to gain experience in reporting accurate information. We also expect reporting on Worksheet S–10 to improve over time, particularly in the area of charity care which is already being used and audited for payment determinations related to the electronic health record incentive program, and will continue to monitor these data. Accordingly, we may proceed with a proposal to use data on the Worksheet S–10 to determine uncompensated care costs in the future, once hospitals are submitting accurate and consistent data through this reporting mechanism.

As we describe above, we are concerned about stakeholder input that the variations in the data reported on Worksheet S–10 of the Medicare cost report regarding uncompensated care may be due to hospitals' relative lack of experience reporting all of the data elements on that worksheet. A large number of stakeholders noted that there is considerable variation and numerous inconsistencies in how uncompensated care is calculated and reported in Worksheet S–10 and they point out that these inconsistencies can produce divergent results. Some went as far as noting that data from Worksheet S–10 is ''flawed'' and many suggested more precision in reporting instructions to help hospitals report data in a more consistent manner. We note that most of the data elements reported on Worksheet S–10 have been previously unused for payment purposes, with only some data elements recently being used for determining a hospital's electronic health record incentive payments, and these data elements have not been subject to audit prior to this time. We believe it is important that data used to determine Factor 3 are data that have been historically publicly available, subject to audit, and used for payment purposes (or that the public understands will be used for payment purposes). It is our belief that hospitals expend more resources to ensure data accuracy when data are publicly available and used for payments. For example, the National Quality Forum (NQF) first endorsed quality measures for readmissions for heart failure (HF) in May 2008 and acute myocardial infarction (AMI) and pneumonia (PN) in October 2008. HF was subsequently adopted in the Hospital Inpatient Quality Reporting Program in the FY 2009 IPPS rule and AMI and PN in the CY2009 OPPS rule. All three were adopted for the FY 2010 HIQR program and publicly reported in Hospital Compare in 2009. More recently, starting in FY 2013, all three were used to determine a payment adjustment under 1886(q). As the measures became linked with payment, CMS has received an increasing number of questions regarding and requests to refine these measures, leading us to believe that hospitals are increasingly focused on ensuring that their data are correct. Furthermore, it is also our belief that auditing plays an important role in ensuring data accuracy by identifying and remediating problem areas and/or hospitals as well as by having a sentinel effect in others. For example, each year, CMS and its intermediaries work with hospitals to review salary and wage data reported on Worksheet S–3 of the Medicare cost report for use in determining the wage index. This extensive process identifies errors and ensures that anomalous data are reviewed, corrected as needed, and documented. Due to stakeholder concerns and our belief in the importance of using data that have been historically publicly available, subject to audit, and used for payment purposes (or that the public understands will be used for payment purposes), for FY 2014, we have serious concerns about proposing using Worksheet S–10 to determine the amount of uncompensated care.

While the statute instructs the Secretary to estimate the amounts of uncompensated care for a period ''based on appropriate data,'' section 1886(r)(2)(C)(i) permits the Secretary to use alternative data ''in the case where the Secretary determines that alternative data is available which is a better proxy for the costs of subsection (d) hospitals for treating the uninsured'' for the numerator of Factor 3. For the denominator of that quotient, section 1886(r)(2)(C)(ii) requires the Secretary to use ''the aggregate amount of uncompensated care for all subsection (d) hospitals that receive a payment under this subsection for such period (*as so estimated, based on such data*). (Emphasis added.) The phrase ''as so estimated, based on such data'' in the latter section can be reasonably interpreted to require the calculation to similarly be based on the same data as is used to estimate the numerator of the quotient in Factor 3, including any alternative data which is determined to be a better proxy for the costs of treating the uninsured. As a result of our concerns regarding variations in the data reported on the Worksheet S–10, we believe that it is appropriate to consider the use of alternative data, at least in FY 2014, the first year that this provision is effective, and possibly additional years until hospitals have adequate experience reporting all of the data elements on Worksheet S–10. We note that this is consistent with input we received from some stakeholders in response to the CMS National Provider Call in January 2013, who stated their belief that existing FY 2010 and FY 2011 data from the Worksheet S–10 cannot be used for implementation of 1886(r) and who requested the opportunity to re-submit the data once more specific instructions were issued by CMS. Accordingly, we examined alternative data sources that could be used to allow time for hospitals to gain experience with and to improve the accuracy of their S–10 reporting. For the reasons described above, we believe it would be appropriate to use data elements that have been historically publicly available, subject to audit, and used for payment purposes (or that the public understands will be used for payment purposes) as alternative data for the first year or years of implementation.

In order to implement the statutory requirements for Factor 3 using alternative data, we must: (1) Determine whether alternative data would be a better proxy for the treatment costs of the uninsured than the information available on the Worksheet S–10; (2) identify a source for this alternative data; and (3) determine the timing and manner of computing the quotient for each hospital.

We believe that data on utilization for insured low-income patients can be a reasonable proxy for the treatment costs of uninsured patients. Moreover, due to the concerns regarding the accuracy and consistency of the data reported on the Worksheet S–10, we believe that this alternative data, which is currently reported on the Medicare cost report, would be a better proxy for the amount of uncompensated care provided by hospitals. Accordingly, we propose to use the utilization of insured low-

income patients defined as inpatient days of Medicaid patients plus inpatient days of Medicare SSI patients as defined in 42 CFR 412.106(b)(4) and 412.106(b)(2)(i), respectively to determine Factor 3. We describe our proposal and rationale more fully below and seek public comment.

As a preliminary matter, we note that precise data on health care costs are difficult to obtain. We note that for Medicare payment purposes, we estimate those costs using reported charges and cost-to-charge ratios. This approach to estimating costs is what is used on Worksheet S–10 to determine costs for charity care and bad debt. Even though we do not believe it is appropriate to look beyond the Medicare cost report for alternative data because all hospitals are required to report data on that cost report, we think that it is important to point out that data on uninsured patients is difficult to find in a comprehensive manner on a hospital-specific basis. In a September 2002 report, Analysis of the Joint Distribution of Disproportionate Share Hospital Payments, RAND and Urban Institute researchers describe this difficulty, citing as an example how detailed inpatient utilization data on self-pay patients were available only for the sample of hospitals (20 percent sample) from the 24 states included in AHRQ's HCUP database.[25]

While Worksheet S–10 does contain some information regarding the treatment costs of the uninsured, most notably of those uninsured patients who qualify for charity care at an individual hospital, for the reasons described above, we are concerned about the use of information reported on the Worksheet S–10 as appropriate data for FY 2014 and possibly additional years. As a result of these concerns, in identifying alternative data that could serve as a proxy for the treatment costs of the uninsured, we must consider methods other than costs to approximate the resources expended by hospitals to treat uninsured patients. One such method is utilization. A hospital's costs for treating uninsured patients are a function of its input costs and utilization of services. In accordance with the statute, in order to determine Factor 3, a hospital-level estimate of uncompensated care is required. Such an estimate can be constructed using detailed data regarding specific items or services. However, such data are not available to us. In contrast, hospital level data measuring utilization as inpatient days or discharges are available. While we note that inpatient days or discharges would be more precise if they took into account the relative resource utilization of individual patients, such as case mix, no such data are available to us. In the September 2002 report discussed above, RAND and Urban Institute researchers asserted that without specific case mix data for low income populations, inpatient days are preferable to discharges as a way to measure utilization. Therefore, we believe that utilization based upon inpatient days is an appropriate method to approximate costs for the treatment costs of the uninsured.

We further believe that utilization by insured low-income patients, such as Medicaid patients or Medicare patients that receive SSI benefits (Medicare SSI), can be a reasonable proxy for utilization by uninsured patients. In its 2000 report on American's Health Care Safety Net, the Institute of Medicine considers uninsured individuals, low-income underinsured individuals, Medicaid beneficiaries, and patients with special health care needs all as vulnerable populations.[26] We note that when studying access to care, researchers may study Medicaid and/or low-income populations (e.g., health outcomes, utilization, etc.) in order to understand more broadly the impact of similar policy interventions for other vulnerable populations.[27] For example, recently, researchers have studied the effects of Medicaid expansions to gauge the effects of these expansions on health status and other indicators to inform policymakers as these expansion efforts continue.[28] Researchers have also studied the ability of Medicaid patients to gain access to outpatient care in an effort to highlight the ramifications of various policy interventions, such as mandatory co-payments and utilization restrictions.[29] We believe that this type research is often used by state and other policy makers to evaluate how Medicaid and other public health insurance can expand access to care to uninsured populations.

While the report by RAND and the Urban Institute cited above found shortcomings in how well both Medicaid and Medicare DSH target funds towards safety net hospitals, another key finding of the report was that the allocation methods used by these programs target funds to safety net hospitals at least as well as the alternative allocation methods they examined. The allocation method used by Medicare for Medicare DSH is the sum of two computations. The first computation, defined at 42 CFR 412.106(b)(2), known as the SSI ratio or Medicare fraction, is the proportion of a hospital's Medicare SSI days relative to Medicare days. The second computation, defined at 42 CFR 412.106(b)(4), known as the Medicaid fraction, is the proportion of a hospital's Medicaid days relative to total days. The by RAND and the Urban Institute study also found that the choice of patient populations used to evaluate how well Medicare and Medicaid DSH funds are allocated is important. The study notes that including Medicare SSI beneficiaries along with all other low-income patients generally performed better, resulting in a better targeting of these payments towards safety net hospitals. Therefore, we believe the utilization of insured low income patients defined as insured low-income days, or inpatient days of Medicaid patients plus inpatient days of Medicare-SSI patients could be a proxy for the treatment costs of uninsured patients. Currently, for the Medicare DSH adjustment, hospitals report utilization for Medicaid and Medicare SSI patients in accordance with the regulations at 42 CFR 412.106(b)(4) and 412.106(b)(2)(i), respectively. Specifically, we would define inpatient days for Medicaid patients as they are defined in 42 CFR 412.106(b)(4) and inpatient days for Medicare-SSI patients as they are defined at § 412.106(b)(2)(i). A hospital's individual insured low-income insured days based on this calculation would represent that hospital's numerator for Factor 3. The sum of the low-income insured days under this calculation for all the hospitals that we estimate would receive DSH payments (and thus the uncompensated care payment) for FY 2014 would represent the denominator of Factor 3.

It is important to point out that when these insured low-income utilization data are used to determine Medicare DSH payments, they are subject to additional computations as described in 42 CFR 412.106(b) and 412.106(d).

[25] Wynn, B. et al. Analysis of the Joint Distribution of Disproportionate Share Hospital Payments. PM–1387–ASPE. September 20, 2002 *http://www.urban.org/UploadedPDF/410975_ASPEDSH_final.pdf.*

[26] Marion Ein Lewin and Stuart Altman, Editors; Committee on the Changing Market, Managed Care, and the Future Viability of Safety Net Providers, Institute of Medicine. America's Health Care Safety Net: Intact but Endangered. 2000. *http://www.nap.edu/catalog/9612.html.*

[27] John K. Iglehart. Medicaid. N Engl J Med 1993; 328:896–900. March 25, 1993.

[28] Benjamin D. Sommers, M.D., Ph.D., Katherine Baicker, Ph.D., and Arnold M. Epstein, M.D. Mortality and Access to Care among Adults after State Medicaid Expansions. N Engl J Med 2012; 367:1025–1034. September 13, 2012.

[29] The Medicaid Access Study Group. Access of Medicaid Recipients to Outpatient Care. N Engl J Med 1994; 330:1426–1430. May 19, 1994.

Therefore, using these data to determine Factor 3 will lead to a different set of results than using these data to determine hospitals' Medicare DSH payments.

We believe that the data in the Medicare cost report (and data that are used to update the SSI ratios in the cost report) are acceptable for use as a source for this alternative data because they include data for all Medicare hospitals. For the reasons described above, we considered data elements from the Medicare cost report that have been historically publicly available, subject to audit, and used for payment purposes, as alternative data for the costs of subsection (d) hospitals for treating the uninsured. Worksheet S–3, Part I of the CMS–2552–96 version of the Medicare cost report and Worksheet S–2, Part I of the CMS 2552–10 version of the Medicare cost report contain information on the utilization of Medicaid patients. Specifically, it contains information regarding Medicaid days (i.e., the numerator of the Medicaid fraction). The SSI ratios can be found in Worksheet E, Part A and hospitals' SSI ratios are reported by CMS on the Medicare DSH Web site, by Federal fiscal year, and include a hospital's Medicare SSI days. We point out that CMS calculates the SSI ratios using the MedPAR claims data and updates them annually in accordance with the process and timing set forth in the FY 2011 IPPS rule (75 FR 50282), generally issuing them in the Spring of each year for the federal fiscal year two years prior. For instance, we would expect that the SSI ratios for FY 2011 would be made available in the Spring of 2013. SSI ratios can be downloaded from *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.html*. The SSI ratios for a Federal fiscal year are the data that would ultimately be used in Worksheet E, Part A to determine a hospital's Medicare DSH adjustment for that fiscal year. While a hospital may choose to have its DSH payments settled using an SSI ratio based on the hospital's cost reporting period, this choice will vary by hospital and the timing of this choice will vary. As a result, a hospital's decision whether to have its SSI ratio calculated on the basis of its cost reporting period may not be available at the time we determine Factor 3 for a specific federal fiscal year. Therefore, in an effort to balance consistency and administrative efficiency with precision, we believe it is appropriate to use the SSI ratios based on the federal fiscal year.

Except for the data on Worksheet S–10, the Medicare cost report does not currently include information that would allow calculation of the treatment costs of uninsured patients. For the reasons described previously, for FY 2014 and possibly additional years, we have concerns with using these data. Accordingly, we propose to use Worksheet S–3 Part I of the CMS–2552–96 version of the Medicare cost report and Worksheet S–2, Part I of the CMS 2552–10 version of the Medicare cost report and data that are used to update the SSI ratios on that Worksheet E, Part A as the source of the alternative data to determine Factor 3 for FY 2014. We may propose to use data from Worksheet S–10 to determine uncompensated care costs in the future, once hospitals are submitting accurate and consistent data through this reporting mechanism.

The statute also allows the Secretary the discretion to determine the time periods from which we will derive the data to estimate the numerator and the denominator of the Factor 3 quotient. Specifically, the statute defines the numerator of the quotient as ''the amount of uncompensated care for such hospital *for a period selected by the Secretary...''* The statute defines the denominator as ''the aggregate amount of uncompensated care for all subsection (d) hospitals that receive a payment under this subsection *for such period.''* (Emphasis added.) As we have discussed above, we are proposing a process of making interim payments with final cost report settlement for both the empirically justified Medicare DSH payments and the uncompensated care payments required by section 3133 of the Affordable Care Act. Consistent with that proposed process, we also are proposing to determine the time period from which to estimate the numerator and denominator of the Factor 3 quotient in a way that will be consistent with making interim and final payments. Specifically, we must have Factor 3 values available for hospitals that we estimate will qualify for Medicare DSH payments using most recently available historical data and for those hospitals that we do not estimate will qualify for Medicare DSH payments but that may ultimately qualify for Medicare DSH payments at the time of cost report settlement.

We are proposing to estimate the numerator and the denominator of Factor 3 for hospitals based on the most recently available full year of Medicare cost report data (including the most recently available data that may be used to update the SSI ratios) with respect to a Federal fiscal year. In other words, we are proposing to use data from the most recently available cost report for the Medicaid days and the most recently available SSI ratios (that is, latest available SSI ratios before the beginning of the Federal fiscal year) for the Medicare-SSI days. We note that these data are publicly available, subject to audit, and used for payment purposes. While we recognize that older data also meet these criteria, we often use the most recently available data for payment determinations. Therefore, for FY 2014, we are proposing to use data from the 2010/2011 cost reports for the Medicaid days and the FY 2011 SSI ratios for the Medicare-SSI days (or, if the FY 2011 SSIs are unavailable, the FY 2010 SSI ratios) to estimate Factor 3 for FY 2014.

To summarize, for FY 2014, in response to stakeholder concerns regarding data variability and lack of reporting experience with Worksheet S–10, we propose to determine Factor 3 using insured low-income patient days from the 2010/2011 cost reports (including the FY2011 or FY 2010 SSI ratios, whichever represents the most recently available inputs prior to October 1, 2013) as alternative data which are a better proxy for the treatment costs of uninsured patients. We further propose to define insured low-income patient days as inpatient days of Medicaid patients plus inpatient days of Medicare SSI patients as defined in 42 CFR 412.106(b)(4) and 412.106(b)(2)(i), respectively.

We are proposing to add a new paragraph (g)(1)(iii) under § 412.106 of our regulations to define the methodology for calculating Factor 3.

We are inviting public comments on this proposal. Notwithstanding our concerns regarding Worksheet S–10, we are interested to hear commenters' views on the quality of the data reported on the Worksheet S–10, and whether it would be sufficient for use in determining uncompensated care amounts for fiscal year 2014, either by itself or in combination with other data. We also seek comment on how fast we could transition to the use of Worksheet S–10 data based upon increased reliability over time, including whether the data could be used to determine uncompensated care in FY 2014 either alone or in combination with other data.

In addition, we are proposing to estimate which hospitals would receive an empirically justified DSH payment in a given Federal fiscal year using the most recent data available. As we described previously, only hospitals that receive Medicare DSH payments in a fiscal year may receive an uncompensated care payment. However, because whether or not a hospital will actually receive Medicare DSH payment is not known until cost report

settlement and cost report settlement occurs several years after end of the federal fiscal year, we believe it is necessary to estimate which hospitals will receive Medicare DSH for a given fiscal year. Because the uncompensated care amounts for these hospitals are used to determine the denominator of Factor 3, this allows for the calculation of Factor 3 in advance of or during the federal fiscal year so that interim payments can begin during the fiscal year. We believe that this will create some level of predictability and finality for hospitals eligible for these payments, in addition to being administratively efficient.

Thus for FY 2014, the denominator for Factor 3 would reflect the estimated Medicaid and Medicare SSI patient days based on data from the 2010/2011 Medicare cost report (including the most recently available data that may be used to update the SSI ratios) for all hospitals that we estimate would receive an empirically justified DSH payment in FY 2014. The numerator of Factor 3 would be the estimated Medicaid and Medicare SSI patient days for the individual hospital based on its most recent 2010/2011 Medicare cost report data (including the most recently available data that may be used to update the SSI ratios). We propose to calculate a numerator for all subsection (d) hospitals and subsection (d) Puerto Rico hospitals that have the potential of receiving a DSH payment regardless of whether we estimate that the hospital would receive DSH payments in the respective Federal fiscal year. In that way, if a hospital becomes eligible to receive the empirically justified DSH payment and also an uncompensated care payment, we will be able to finalize its uncompensated care payment efficiently and without affecting the uncompensated care payments of other hospitals.

We believe that this proposed approach strikes an appropriate balance between administrative efficiency, finality, and predictability in payments. Therefore, we also are proposing to publish a table or tables listing Factor 3 for all hospitals that we estimate would receive empirically justified DSH payments in a fiscal year (that is, hospitals that would receive interim uncompensated care payments during the fiscal year), and for the remaining subsection (d) and subsection (d) Puerto Rico hospitals that have the potential of receiving a DSH payment in the event that they receive an empirically justified DSH payment for the fiscal year as determined at cost report settlement. We are also proposing that hospitals have 60 days from the date of display of the IPPS/LTCH PPS proposed rule to review these tables and notify CMS in writing of a change in a hospital's subsection (d) hospital status, such as if a hospital has closed or converted to a CAH. We will notify hospitals concerning the specifics of this process in program instructions after the final rule. For FY 2014, we will allow hospitals 60 days from the date of display of the IPPS/LTCH PPS proposed rule to review these tables and notify CMS in writing of a change in a hospital's subsection (d) hospital status, and we may allow an additional (perhaps shorter) such period after the publication of the final rule. For hospitals that were not estimated to receive an empirically justified DSH payment for a fiscal year, but ultimately qualify for such a payment at cost report settlement, we would make the full uncompensated care payment at that time. In the case of hospitals that we estimated would receive an empirically justified Medicare DSH payment for a fiscal year and that received interim empirically justified Medicare DSH payments and uncompensated care payments, but are found to be ineligible for DSH payments at cost report settlement, we would recover the overpayment. However, we are proposing only to calculate the denominator once, at the time of the IPPS/LTCH PPS final rule each year. We are not proposing to recalculate the denominator at the time when cost reports are settled and final eligibility determinations for uncompensated care (and empirically justified Medicare DSH) payments are made. We discuss our proposals for interim payments and reconciliation processes later in this preamble.

For the purpose of this proposed rule, we are posting proposed tables listing Factor 3 for the hospitals that we have estimated would receive Medicare DSH payments for FY 2014 on the CMS Web site at: *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.html*. We request that hospitals review these tables. In order to ensure that we have sufficient time to incorporate any updated information in the tables for the final rule, hospitals should notify CMS in writing within 60 days from the date of display of this proposed rule of any change in a hospital's subsection (d) hospital status. As we state above, for FY 2014, we may allow an additional (perhaps shorter) such period after the publication of the final rule.

Our estimates of eligibility to receive FY 2014 Medicare DSH payments are based on the December 2012 update of the Provider Specific File that lists the most recently available DSH patient percentage (DPP) and DSH payment adjustments for hospitals that qualify to receive DSH payments. We estimate that 2,349 hospitals, or 68 percent of all applicable hospitals, would be eligible for DSH payments in FY 2014. The proposed Factor 3 is based on the December 2012 update of the Medicare Hospital Cost Report and FY 2010 SSI ratios. The data from these 2,349 hospitals is used to determine the denominator for Factor 3. However, we will estimate a Factor 3 numerator for each subsection (d) and subsection (d) Puerto Rico hospital that has the potential of receiving DSH payments for FY 2014 and therefore of qualifying for the uncompensated care payment in FY 2014. We intend to update in the final rule the list of hospitals that we estimate will be eligible for DSH payments for FY 2014 and our estimate of Factor 3 using more recent data and verified hospital notifications regarding hospital status (for example, closures).

e. Limitations on Review

Section 1886(r)(3) of the Act provides that there will be no administrative or judicial review under section 1869 of the Act, 1878 of the Act, or otherwise for any of the following:

- Any estimate of the Secretary for purposes of determining the factors described in paragraph (2) of section 1886(r) of the Act.
- Any period selected by the Secretary for such purposes.

We are proposing to codify this policy in new § 412.106(g)(2) of our regulations.

We invite public comment on this proposal.

f. Proposed Operational Considerations

As discussed earlier in section V.F.3.d. of the preamble of this proposed rule, and in accordance with section 1886(r)(2) of the Act, only subsection (d) hospitals that receive empirically justified Medicare DSH payments in a given Federal fiscal year will also receive the uncompensated care payment (that is, Factor 1 times Factor 2 times Factor 3) for that given Federal fiscal year. In addition, as discussed above in this section, we are proposing that subsection (d) Puerto Rico hospitals that receive empirically justified Medicare DSH payments in a given Federal fiscal year would also receive the uncompensated care payment (that is, Factor 1 times Factor 2 times Factor 3) for that given Federal fiscal year. As we discussed above, we intend to estimate Factor 3 for each subsection (d) and subsection (d) Puerto Rico hospital with the potential to receive a DSH payment prior to the

beginning of the Federal fiscal year and intend to make that information available via our Web site. *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.html*.

Specifically, we are proposing to make interim uncompensated care payments on the basis of our best available estimates concerning the eligibility of each hospital for empirically justified Medicare DSH payments and our best available calculations concerning the amount of the uncompensated care payments that the hospital is eligible to receive. We intend to make these interim uncompensated care payments on a periodic basis and not on a per discharge basis. As discussed above, we believe that this approach is more consistent with the plain language of the statute describing the additional payment, which includes no information from which it would be possible to infer that the payment should be made on a per discharge basis. We believe that this is the most administratively efficient means to distribute a set dollar amount to individual hospitals and also creates an appropriate level of predictability for hospitals. If we were to make these interim uncompensated care payments on a per discharge basis, unless a hospital's Medicare utilization is identical to the period used to determine the per discharge payment level, it is certain that Medicare would overpay or underpay. By making interim payments periodically, we can virtually eliminate the possibility that Medicare pays a higher or lower amount than intended and limit the need for reconciliation to whether a hospital is eligible for Medicare DSH and thus the entire uncompensated care payment at cost report settlement.

We also are proposing to make a final determination concerning eligibility for uncompensated care payments at the time of cost report settlement. As a result of this proposal, our operational system must be able to handle the various situations that may arise between interim and final eligibility determinations. For example, a hospital may receive empirically justified DSH payments and uncompensated care payments based on an initial determination that the hospital is eligible for such payments, but the hospital may then be determined to be ineligible for such payments at cost report settlement. In such situations, we must be prepared and able to recoup the interim empirically justified DSH payments and uncompensated care payments that the hospital received.

For each Federal fiscal year, as we proposed earlier in this section, we intend to estimate which hospitals will receive an empirically justified DSH payment (that is, eligible hospitals). We are proposing to provide periodic payments to these hospitals during the relevant Federal fiscal year so that they can receive their uncompensated care payments on an interim basis. For a fiscal year, each eligible hospital's interim uncompensated care payments will be determined by multiplying the final values for Factor 1, Factor 2, and Factor 3 for that year and dividing the amount by the number of periods over which the interim payments will be made.

Because we are using historical data to estimate each hospital's eligibility for empirically justified DSH payments in FY 2014 and subsequent years, a reconciliation process will be necessary to account for cases in which a hospital's eligibility for such payments changes after we have published our estimates during the rulemaking process. For example, a hospital that had not been estimated to be eligible for these payments may become eligible during the course of a given payment period. In such cases, our estimates would have indicated that the hospital was ineligible for empirically justified DSH payments and therefore ineligible for uncompensated care payments. That hospital would not receive interim payments. However, if the data available at cost report settlement were to indicate that the hospital is eligible for an empirically justified DSH payment, the hospital would become eligible for an uncompensated care payment based on that hospital's Factor 3 value.

Therefore, we are proposing that at cost report settlement, the fiscal intermediary/MAC will make a final determination concerning whether each hospital is eligible for empirically justified Medicare DSH payments and, therefore, uncompensated care payments in FY 2014 and each subsequent year. In the case where a hospital received interim payments for its empirically justified Medicare DSH payments and uncompensated care payments for FY 2014 or a subsequent year on the basis of estimates prior to the payment year, but is determined to be ineligible for the empirically justified Medicare DSH payment at cost report settlement, the hospital would no longer be eligible for either payment and CMS would recoup those monies. For a hospital that did not receive interim payments for its empirically justified DSH payments and uncompensated care payments for FY 2014 or a subsequent year, but at cost report settlement is determined to be eligible for DSH payments, the fiscal intermediary/MAC would calculate the uncompensated care payment for such a hospital based on the Factor 3 value determined prospectively for that fiscal year.

We are proposing to codify this policy regarding the manner and timing of payments in new § 412.106(h) of our regulations.

We invite public comment on this proposal.

The reconciliations at cost report settlement would be based on the values for Factor 1, Factor 2, and Factor 3 that we have finalized prospectively for a Federal fiscal year. For example, a hospital that was estimated by CMS to receive empirically justified DSH payments for FY 2014 and received interim uncompensated care payments would not receive a different uncompensated care payment amount if the fiscal intermediary/MAC determined that the hospital remained eligible for empirically justified DSH payments at cost report settlement. In other words, we are not proposing to include a reestimation of Factor 1, Factor 2, or Factor 3 in the reconciliation process we are describing. Rather, Factor 1, Factor 2, and Factor 3 are estimates determined prospectively using methodologies we establish through rulemaking. We recognize that, under this proposal, we may pay a total amount that could either be more or less than the product of Factor 1 and Factor 2. However, we believe this is inherent in the use of estimates to determine the Factors, similar to the manner in which we estimate the amount of total outlier payments under section 1886(d)(5)(A)(iv) although, as in this case, the amount of actual total outlier payments might vary from that estimate. We do not know of any reason to believe that there will be a bias toward systematic overpayment or underpayment from year to year.

We are proposing to codify this policy at § 412.106(g)(1)(iv) of our regulations.

We are inviting public comments on this proposal, especially in regard to whether we should include Factor 3 within the reconciliation process. Depending on the comments, we may revise our proposed policy in the final rule so that at the time of cost report settlement and reconciliation a hospital's final uncompensated care payments could be based on Factor 3 numerators and denominators estimated using more recent cost report data (and associated inputs). In addition, we may revise our proposed reconciliation process, as appropriate, to account for any policy changes that we make in the

final rule to the proposals in this proposed rule.

We also note that the uncompensated care payment will be reported on the Medicare Hospital Cost Report. We recognize that hospitals have their own cost reporting periods that may differ from the Federal fiscal year and that may span more than one Federal fiscal year. We are proposing that hospitals receive their uncompensated care payments with respect to the fiscal year in which their cost report begins. For example, if a hospital is estimated to be eligible for the empirically justified DSH payment and also an uncompensated care payment in FY 2014 and has a cost report period of January 1, 2014 through December 31, 2014, this hospital would begin to receive interim payments for its uncompensated care on October 1, 2013. If, at cost report settlement, this hospital remained eligible for an empirically justified DSH payment, then the hospital would receive its FY 2014 uncompensated care payment on its cost report for the cost reporting period beginning on January 1, 2014 (that is, the hospital would neither owe nor be owed monies for its uncompensated care payment). As another example, if that same hospital is no longer eligible for an empirically justified Medicare DSH payment at the time of settlement of its cost report for the cost reporting period beginning January 1, 2014, the hospital would be required to pay back the interim payments it received for its uncompensated care payments. We note that this methodology would not delay the full payment of FY 2014 payments to hospitals with cost reporting periods that begin after October 1, 2013. While it is possible to align interim and final payments for the uncompensated care payment with individual hospital's cost reporting periods, we believe it administratively efficient and practical to pay the uncompensated care payment on the basis of the Federal fiscal year because that is how it is determined, and to reconcile that amount in the cost reporting period that begins in the respective Federal fiscal year. If this proposal is finalized, we will revise the cost report accordingly. We are inviting public comments on our proposal.

g. National Provider Call

On January 8, 2013, CMS hosted a National Provider Call regarding the implementation of section 3133 of the Affordable Care Act. During this call, CMS asked Dobson DaVanzo and Associates, LLC. with its subcontractor, KNG Health Consulting, LLC, to present information regarding alternative definitions, measures, and data sources for the various estimates required by section 1886(r) of the Act, including the rate of uninsured individuals under the age of 65 years and hospital-specific uncompensated care. Approximately 1,304 participants participated in this call. The presentation materials from the call are available on the CMS Web site at: *http://www.cms.gov/Outreach-and-Education/Outreach/NPC/National-Provider-Calls-and-Events-Items/2013-01-08-ACA* to submit public comments to CMS for consideration through January 15, 2013, when we undertook rulemaking and other activities related to implementation of section 1886(r) of the Act. Approximately 64 organizations submitted comments either on the National Provider Call or subsequent to the National Provider Call. We appreciate this input and have considered the issues raised by the commenters in developing the proposals discussed above. The report ''Improvements to Medicare Disproportionate Share (DSH) Payments'' discusses the issues raised in this National Provider Call. A summary of the comments on the National Provider Call has also been prepared. The report and summary can be found on the CMS Web site at: *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.html*.

F. Medicare-Dependent, Small Rural Hospital (MDH) Program (§ 412.108)

1. Backgound

Section 1885(d)(5)(G) of the Act provides special payment protections, under the IPPS, to a Medicare-dependent, small rural hospital (MDH). (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 Public Law 109–171 (DRA 2005), the MDH program was to be in effect through the end of FY 2011 only. Section 3124(a) of the Affordable Care Act amended sections 1886(d)(5)(G)(i) and 1886(d)(5)(G)(ii)(II) of the Act to extend the MDH program and payment methodology by striking out ''October 1, 2011'' and inserting ''October 1, 2012''. Section 3124(b) of the Affordable Care Act made conforming amendments to sections 1886(b)(3)(D) and 1886(b)(3)(D)(iv) of the Act.

In the FY 2011 IPPS/LTCH PPS final rule (75 FR 50287 and 50414), we amended the regulations at § 412.108(a)(1) and (c)(2)(iii) to reflect the statutory extension of the MDH program through FY 2012. In the FY 2012 IPPS/LTCH PPS final rule (76 FR 51683 through 51684), we did not make any additional changes to the MDH regulatory text for FY 2012. As discussed below, the ATRA (Pub. L. 112–240) amended the Act to extend the MDH program through the end of FY 2013.

2. Provisions of the ATRA for FY 2013

a. Background

Prior to the enactment of the ATRA, under section 3124 of the Affordable Care Act, the MDH program authorized by section 1886(d)(5)(G) of the Act was set to expire at the end of FY 2012. Section 606 of the ATRA 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 October 1, 2012 to September 30, 2013 (FY 2013). Section 606 of the ATRA also made conforming amendments to sections 1886(b)(3)(D)(i) and 1886(b)(3)(D)(iv) of the Act. Prior to the enactment of the ATRA, in the FY 2013 IPPS/LTCH PPS final rule, we discussed the expiration of the MDH program at the end of FY 2012 (77 FR 53413 through 53414) and revised the SCH regulation at § 412.92(b) to change the effective date of SCH status for MDHs that apply for SCH status with the expiration of the MDH program (77 FR 53404 through 53405).

In a FY 2013 IPPS notice issued in the **Federal Register** on March 7, 2013 (78 FR 14689), we announced the extension of the MDH program for FY 2013 in accordance with the provisions of section 606 of the ATRA. In that notice, we explained that, as a result of section 606 of the ATRA, the MDH program is now extended for 1 additional year, through the end of FY 2013 (that is, effective October 1, 2012 through September 30, 2013). The FY 2013 IPPS notice explained how providers may be affected by the ATRA extension of the MDH program and described the steps to reapply for MDH status for FY 2013, as applicable. Generally, a provider that was classified as an MDH at the end of FY 2012 (that is, as of September 30, 2012) will be reinstated as an MDH effective October 1, 2012, with no need to reapply for MDH classification. However, if the MDH had classified as

admitting privileges applicable to that patient by the hospital's medical staff.

(c) Except as specified in paragraph (c)(2) of this section—

(1) When a patient enters a hospital for a surgical procedure not specified by Medicare as inpatient only under § 419.22(n) of this chapter, a diagnostic test, or any other treatment, and the physician expects to keep the patient in the hospital for only a limited period of time that does not cross 2 midnights, the services are generally inappropriate for inpatient payment under Medicare Part A, regardless of the hour that the patient came to the hospital or whether the patient used a bed. Surgical procedures, diagnostic tests, and other treatment are generally appropriate for inpatient hospital payment under Medicare Part A when the physician expects the patient to require a stay that crosses at least 2 midnights. The expectation of the physician should be based on such complex medical factors as patient history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event. The factors that lead to a particular clinical expectation must be documented in the medical record in order to be granted consideration.

(2) If an unforeseen circumstance, such as a beneficiary's death or transfer, result in a shorter beneficiary stay than the physician's expectation of at least 2 midnights, the patient may be considered to be appropriately treated on an inpatient basis, and hospital inpatient payment may be made under Medicare Part A.

■ 3. Section 412.46 is revised to read as follows:

§ 412.46 Medical review requirements.

(a) *Physician acknowledgement.* (1) *Basis.* Because payment under the prospective payment system is based in part on each patient's principal and secondary diagnoses and major procedures performed, as evidenced by the physician's entries in the patient's medical record, physicians must complete an acknowledgement statement to this effect.

(2) *Content of physician acknowledgement statement.* When a claim is submitted, the hospital must have on file a signed and dated acknowledgement from the attending physician that the physician has received the following notice: Notice to Physicians: Medicare payment to hospitals is based in part on each patient's principal and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient's attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds, may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.

(3) *Completion of acknowledgement.* The acknowledgement must be completed by the physician at the time that the physician is granted admitting privileges at the hospital, or before or at the time the physician admits his or her first patient. Existing acknowledgements signed by physicians already on staff remain in effect as long as the physician has admitting privileges at the hospital.

(b) *Physician's order and certification regarding medical necessity.* No presumptive weight shall be assigned to the physician's order under § 412.3 or the physician's certification under subpart B of part 424 of the chapter in determining the medical necessity of inpatient hospital services under section 1862(a)(1) of the Act. A physician's order or certification will be evaluated in the context of the evidence in the medical record.

■ 4. Section 412.64 is amended—

■ a. By adding paragraph (d)(1)(v).

■ b. In paragraph (h)(4) introductory text, by removing the date ''October 1, 2013'' and adding in its place the date ''October 1, 2014''.

■ c. In paragraph (h)(4)(vi), by removing the date ''October 1, 2013'' and adding in its place the date ''October 1, 2014''.

The addition reads as follows:

§ 412.64 Federal rates for inpatient operating costs for Federal fiscal year 2005 and subsequent fiscal years.

* * * * *

(d) * * *

(1) * * *

(v) For fiscal year 2014, the percentage increase in the market basket index less a multifactor productivity adjustment (as determined by CMS) and less 0.3 percentage point for prospective payment hospitals (as defined in § 413.40(a) of this chapter) for hospitals in all areas.

* * * * *

§ 412.101 [Amended]

■ 5. Section 412.101 is amended—

■ a. In paragraph (b)(2)(i), by removing the term ''FY 2013'' and adding in its place the term ''FY 2014.''

■ b. In paragraph (b)(2)(ii), by removing the phrase ''For FY 2011 and FY 2012,'' and adding in its place the phrase ''For FY 2011, FY 2012, and FY 2013,''.

■ c. In paragraph (c)(1), by removing the term ''FY 2013'' and adding in its place the term ''FY 2014.''

■ d. In paragraph (c)(2) introductory text, by removing the phrase ''For FY 2011 and FY 2012,'' and adding in its place the phrase ''For FY 2011, FY 2012, and FY 2013,''.

■ e. In paragraph (d), by removing the term ''FY 2013'' and adding in its place the term ''FY 2014.''

■ 6. Section 412.106 is amended by adding paragraphs (f), (g), and (h) to read as follows:

§ 412.106 Special treatment: Hospitals that serve a disproportionate share of low-income patients.

* * * * *

(f) *Empirically justified Medicare DSH payments.* Effective for discharges on or after October 1, 2013, the amounts otherwise payable to a hospital under paragraph (d) of this section are reduced by 75 percent.

(g) *Additional payment for uncompensated care.* (1) *Payment rules.* Hospitals that qualify for payments under this section for fiscal year 2014 and each subsequent year, will receive an additional amount equal to the product of the following three factors:

(i) *Factor 1.* For FY 2014 and each subsequent fiscal year, a factor equal to the difference between:

(A) The most recently available estimates, as calculated by CMS' Office of the Actuary, of the aggregate amount of payments that would be made to such hospitals under paragraphs (a) through (e) of this section if paragraph (f) of this section did not apply for the fiscal year; and

(B) The most recently available estimates, as calculated by CMS' Office of the Actuary, of the aggregate amount of payments that are made to such hospitals pursuant to paragraph (f) of this section for the fiscal year.

(ii) *Factor 2.* For each of fiscal years 2014, 2015, 2016, and 2017, a factor equal to 1 minus the percent change in the percent of individuals under the age of 65 who are uninsured (and subtracting from the factor 0.1 percentage point for fiscal year 2014 and 0.2 percentage point for each of fiscal years 2015, 2016, and 2017), as determined by comparing:

(A) 18 percent, the percent of such individuals who are uninsured in 2013, based on the March 20, 2010 estimate of the ''Insured Share of the Nonelderly Population Including All Residents'' by the Congressional Budget Office; and

(B) The percent of such individuals who are uninsured in the applicable fiscal year, based on the most recent estimate of the ''Insured Share of the Nonelderly Population Including All Residents'' by the Congressional Budget Office available at the time of development of the annual final rule for the hospital inpatient prospective payment system.

(iii) *Factor 3.* A factor equal to the percent, for each inpatient prospective payment system hospital, that represents the quotient of:

(A) The amount of uncompensated care for such hospital as estimated by CMS.

(B) The aggregate amount of uncompensated care as estimated by CMS for all hospitals that are estimated to receive a payment under this section.

(C) Beginning with fiscal year 2014, CMS will base its estimates of the amount of hospital uncompensated care on the most recent available data on utilization for Medicaid and Medicare SSI patients, as determined by CMS in accordance with paragraphs (b)(2)(i) and (b)(4) of this section.

(iv) The final values for each of the three factors are determined for each fiscal year at the time of development of the annual final rule for the hospital inpatient prospective payment system, and these values are used for both interim and final payment determinations.

(2) *Preclusion of administrative and judicial review.* There is no administrative or judicial review under sections 1869 or 1878 of the Act, or otherwise, of the following:

(i) Any estimate of the Secretary for the purpose of determining the factors in section paragraph (g)(1) of this section; and

(ii) Any period selected by the Secretary for such purposes.

(h) *Manner and timing of payments.* (1) Interim payments are made on a periodic basis during the payment year to each hospital that is estimated to be eligible for payments under this section at the time of the annual final rule for the hospital inpatient prospective payment system, subject to the final determination of eligibility at the time of cost report settlement for each hospital.

(2) Final payment determinations are made at the time of cost report settlement, based on the final determination of each hospital's eligibility for payment under this section.

§ 412.108 [Amended]

■ 7. Section 412.108 is amended—

■ a. In paragraph (a)(1) introductory text, by removing the phrase ''before October 1, 2012'' and adding in its place the phrase ''before October 1, 2013''.

■ b. In paragraph (c)(2)(iii) introductory text, by removing the phrase ''before October 1, 2012'' and adding in its place the phrase ''before October 1, 2013''.

■ 8. Section 412.140 is amended by revising the section heading and paragraphs (a)(3) introductory text and (b) and adding paragraph (f) to read as follows:

§ 412.140 Participation, data submission, and validation requirements under the Hospital Inpatient Quality Reporting (IQR) Program.

(a) * * *

(3) Submit a completed Notice of Participation Form to CMS if the hospital is participating in the program for the first time, has previously withdrawn from the program and would like to participate again, or has received a new CMS Certification Number (CCN).

* * * * *

(b) *Withdrawal from the Hospital IQR Program.* CMS will accept Hospital IQR Program withdrawal forms from hospitals on or before—

(1) Prior to the FY 2016 payment determination, August 15 of the fiscal year preceding the fiscal year for which a Hospital IQR determination will be made.

(2) Beginning with the FY 2016 payment determination, May 15 of the fiscal year preceding the fiscal year for which a Hospital IQR payment determination will be made.

* * * * *

(f) *Patient experience of care data (HCAHPS survey).* HCAHPS is the Hospital Consumer Assessment of Healthcare Providers and Systems survey that measures patient experience of care after a recent hospital stay.

(1) Approved HCAHPS survey vendors and self-administering hospitals must fully comply with all HCAHPS oversight activities, including allowing CMS and its HCAHPS Project Team to perform site visits at the hospitals' and survey vendors' company locations.

(2) CMS approves an application for an entity to administer the HCAHPS survey as an approved HCAHPS survey vendor on behalf of one or more hospitals when an applicant has met the Minimum Survey Requirements and Rules of Participation listed in the most recently available version of the HCAHPS *Quality Assurance Guidelines,* available on the official HCAHPS On-Line Web site, and agree to comply with the survey administration protocols contained in the most recently available version of the HCAHPS *Quality Assurance Guidelines* and as updated through HCAHPS Bulletins and announcements on the official HCAHPS On-Line Web site. An entity must be an approved HCAHPS survey vendor in order to administer and submit HCAHPS data to CMS on behalf of one or more hospitals.

■ 9. Section 412.150 is amended by adding paragraph (c) to read as follows:

§ 412.150 Basis and scope of subpart.

* * * * *

(c) Section 1886(p) of the Act requires the Secretary to establish an adjustment to hospital payments for hospital-acquired conditions, or a Hospital-Acquired Condition Reduction Program, under which payments to applicable hospitals are adjusted to provide an incentive to reduce hospital-acquired conditions, effective for discharges beginning on October 1, 2014. The rules for determining the payment adjustment under the Hospital-Acquired Condition Reduction Program are specified in §§ 412.170 and 412.172.

■ 10. Section 412.152 is amended by revising the definition of ''Base operating DRG payment amount'' to read as follows:

§ 412.152 Definitions for the Hospital Readmissions Reduction Program.

* * * * *

Base operating DRG payment amount is the wage-adjusted DRG operating payment plus any applicable new technology add-on payments under subpart F of this part. This amount is determined without regard to any payment adjustments under the Hospital Value-Based Purchasing Program, as specified under § 412.162. This amount does not include any additional payments for indirect medical education under § 412.105, the treatment of a disproportionate share of low-income patients under § 412.106, outliers under subpart F of this part, and a low volume of discharges under § 412.101. With respect to a sole community hospital that receives payments under § 412.92(d) or a Medicare-dependent, small rural hospital that receives payments under § 412.108(c) for FY 2013, this amount also does not include the difference between the hospital-specific payment rate and the Federal payment rate determined under subpart D of this part. With respect to a hospital that is paid under section 1814(b)(3) of the Act, this amount is an amount equal to the wage adjusted DRG payment amount plus new technology payments that would be paid to such hospitals, absent the provisions of section 1814(b)(3) of the Act.

* * * * *

■ 11. Section 412.154 is amended by revising paragraph (d)(2) to read as follows:

§ 412.154 Payment adjustments under the Hospital Readmissions Reduction Program.

* * * * *

(d) * * *

(2)(i) Maryland's annual report to the Secretary and request for exemption