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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 412

[CMS-1599-IFC]

RIN 0938-AR53

Medicare Program; FY 2014 Inpatient Prospective Payment Systems: Changes to Certain Cost Reporting Procedures Related to Disproportionate Share Hospital Uncompensated Care Payments

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

ACTION: Interim final rule with comment period.

SUMMARY: In the fiscal year (FY) 2014 inpatient prospective payment systems (IPPS)/long-term care hospital (LTCH) PPS final rule, we established the methodology for determining the amount of uncompensated care payments made to hospitals eligible for the disproportionate share hospital (DSH) payment adjustment in FY 2014 and a process for making interim and final payments. This interim final rule with comment period revises certain operational considerations for hospitals with Medicare cost reporting periods that span more than one Federal fiscal year and also makes changes to the data that will be used in the uncompensated care payment calculation in order to ensure that data from Indian Health Service (IHS) hospitals are included in Factor 1 and Factor 3 of that calculation.

DATES: Effective date: These regulations are effective on October 1, 2013.

Comment date: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on November 29, 2013.

ADDRESSES: In commenting, please refer to file code CMS-1599-IFC. 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 to **<http://www.regulations.gov>**. Follow the "Submit a comment" instructions.

2. By regular mail. You may mail written comments to the following address ONLY:

Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS-1599-IFC,
P.O. Box 8013,
Baltimore, MD 21244-8013.

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 to the following address ONLY:

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

4. By hand or courier. Alternatively, you may deliver (by hand or courier) your

written comments ONLY to the following addresses prior to the close of the comment period:

a. For delivery in Washington, DC--

Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Room 445-G, Hubert H. Humphrey Building,
200 Independence Avenue, SW.,
Washington, DC 20201

(Because access to the interior of the Hubert H. Humphrey 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. For delivery in Baltimore, MD--

Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
7500 Security Boulevard,
Baltimore, MD 21244-1850.

If you intend to deliver your comments to the Baltimore address, call telephone number (410) 786-9994 in advance to schedule your arrival with one of our staff members.

Comments erroneously 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 or Ing Jye Cheng, (410) 786-4548.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been received: <http://regulations.gov>. Follow the search instructions on that Web site to view public comments.

Comments received timely will be also available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1-800-743-3951.

I. Background

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 Social Security Act (the Act) that modifies the methodology for computing the Medicare disproportionate share hospital (DSH) payment adjustment beginning in fiscal year (FY) 2014. For the purposes of this interim final rule with comment period, we refer to these provisions collectively as section 3133 of the Affordable Act. Currently, hospitals

qualify for a DSH payment adjustment under a statutory formula that considers their Medicare utilization due to beneficiaries who also receive Supplemental Security Income (SSI) benefits and their Medicaid utilization. Under section 1886(r) of the Act, starting in FY 2014, hospitals that are eligible for Medicare DSH payments will receive 25 percent of the amount they previously would have received under the current statutory formula for Medicare DSH payments. The remaining amount, equal to an estimate of 75 percent of what otherwise would have been paid as Medicare DSH payments, reduced for 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. Each Medicare DSH hospital will receive an additional amount based on its estimated share of the total amount of uncompensated care reported for all Medicare DSH hospitals for a given time period. In this interim final rule with comment period, we are revising certain policies and processes described in the FY 2014 IPPS/LTCH PPS final rule. Specifically, we are revising certain operational considerations for hospitals with Medicare cost reporting periods that span more than one Federal fiscal year and also making changes to the data that will be used in the uncompensated care payment calculation in order to ensure that data from Indian Health Service (IHS) hospitals are included in Factor 1 and Factor 3 of that calculation.

In the final rule titled "Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2014 Rates; Quality Reporting Requirements for Specific Providers; Hospital Conditions of Participation; Payment Policies Related to Patient Status" (which appeared in the August 19, 2013 **Federal Register** (78 FR 50496)), we made payment and policy changes under the Medicare

inpatient prospective payment systems (IPPS) for operating costs of acute care hospitals. Section 1886(r) of the Act, as added by section 3133 of the Affordable Care Act, provides for a reduction to disproportionate share payments under section 1886(d)(5)(F) of the Act and for a new uncompensated care payment to eligible hospitals. Specifically, section 1886(r) of the Act now requires that, for "fiscal year 2014 and each subsequent fiscal year," "subsection (d) hospitals" that would otherwise receive a "disproportionate share payment . . . made under subsection (d)(5)(F)" will receive two separate payments: (1) 25 percent of the amount they previously would have received under subsection (d)(5)(F) for DSH ("the empirically justified amount"); and (2) an additional payment for the DSH hospital's proportion of uncompensated care, determined as the product of three factors. These three factors are: (1) 75 percent of the payments that would otherwise be made under subsection (d)(5)(F); (2) 1 minus the percent change in the percent of individuals under the age of 65 who are uninsured (minus 0.1 percentage points for FY 2014, and minus 0.2 percentage points for FY 2015 through FY 2017); and (3) a hospital's uncompensated care amount relative to the uncompensated care amount of all DSH hospitals expressed as a percentage.

II. Provisions of the Interim Final Rule

A. Operational Considerations for Hospitals With Medicare Cost Reporting Periods That Span More Than One Federal Fiscal Year

In the FY 2014 IPPS/LTCH PPS final rule (78 FR 50645), we finalized "a process to distribute interim uncompensated care payments under the IPPS on a per-discharge basis through our claims processing system, with a reconciliation of the hospitals' [uncompensated care] payments at cost report settlement to ensure that hospitals receive no more than the estimated amount included in this final rule". We described that

process as follows (78 FR 50646):

[A]t cost report settlement, the fiscal intermediary/MAC will issue a notice of program reimbursement that includes a determination concerning whether each hospital is eligible for empirically justified Medicare DSH payments and, therefore, eligible for 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 Medicare 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 uncompensated care payment for such a hospital is calculated based on the Factor 3 value determined prospectively for that fiscal year. . . . 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.

In the final rule (78 FR 50646), we provided an example in which a DSH eligible hospital has a cost reporting period of January 1, 2014 through December 31, 2014. We stated that this hospital would receive interim payments for its uncompensated care payments beginning on October 1, 2013. For cost reporting purposes, we stated that the uncompensated care payments for federal FY 2014 would be assigned to cost reporting periods beginning on or after October 1, 2013, and would be reconciled on those cost reports. Thus, in the example of the hospital with a cost reporting period beginning on January 1, 2014, if the hospital remained eligible for empirically justified DSH payments at cost report settlement, then it would receive its full FY 2014 uncompensated care payment on its cost report for the cost reporting period beginning on January 1, 2014. Although we acknowledged that it is possible to align interim and final payments for the uncompensated care payment with an individual hospital's cost reporting periods, we

believed it would be 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. We stated in the final rule (78 FR 50647) that we believed this methodology would not delay the full payment of FY 2014 payments to hospitals with cost reporting periods that begin after October 1, 2013.

However, as we prepared to implement the FY 2014 IPPS/LTCH PPS final rule, several difficulties regarding this approach that we had not previously considered came to our attention. We initially proposed to make interim uncompensated care payments on a bi-weekly basis, finalizing a different process to make interim uncompensated care payments on a per-discharge basis in response to comments. In addition to proposing and finalizing a process for making interim uncompensated care payments, we also proposed and finalized a reconciliation process that would reconcile the uncompensated care payment for a given fiscal year, such as FY 2014, on the cost report for the cost reporting period beginning in that fiscal year (that is, for FY 2014, the cost report for the cost reporting period beginning in FY 2014). We proposed and finalized this approach because we believed it would be administratively efficient and practical. As indicated previously and in the FY 2014 IPPS/LTCH PPS final rule, we believed that this policy would neither delay nor substantially affect the disbursement of final uncompensated care payments; but, since the final rule was issued, we have come to doubt these conclusions. We have come to believe that the policy we adopted in the FY 2014 IPPS/LTCH PPS final rule is inconsistent with longstanding cost reporting requirements. As a general rule, payments for discharges are reported in the cost reporting period in which they occur, and all payments made for discharges during a cost reporting period are reconciled

on the cost report for that period. (See PRM-I, Section 2805 and 42 CFR 412.1(a)). We did not specifically address or propose to change the cost reporting rules in either the FY 2014 IPPS/LTCH PPS proposed or final rules. However, for hospitals with cost reporting periods that are not concurrent with the Federal fiscal year, the policy adopted in the FY 2014 IPPS/LTCH PPS final rule departs from these cost reporting requirements by reconciling interim uncompensated care payments made for discharges occurring during the hospital's 2013 cost reporting period on the hospital's 2014 cost report. Under ordinary cost reporting requirements, those payments (having been made during the hospital's 2013 cost reporting period) would have to be treated as an overpayment on the hospital's 2013 cost report and therefore recouped. However, as finalized in the FY 2014 IPPS/LTCH PPS final rule, if the hospital was found to be eligible for DSH payments for its cost reporting period that begins during FY 2014, we would then pay the hospital its full FY 2014 uncompensated care payment during the settlement of the hospital's 2014 cost report (that is, we would repay the previously recouped uncompensated care payments when we reconciled the hospital's 2014 cost report). These administrative issues would effectively delay uncompensated care payments, frustrate our policy of making uncompensated care payments promptly, and would likely lead to serious cash flow difficulties for some hospitals. In sum, we do not believe the policy we finalized in the FY 2014 IPPS/LTCH PPS final rule of reconciling uncompensated care payments for hospitals with cost reporting periods that begin after October 1, 2013 would work as intended for the large majority of IPPS hospitals that have cost reporting periods that are not concurrent with the Federal fiscal year.

To effectuate a revised process, we intend to align final payments for the uncompensated care payment with each individual hospital's cost reporting periods and to

reconcile interim uncompensated care payment amounts on the hospital's cost report for the proportion of the cost reporting period that overlaps a Federal fiscal year and in which the interim payments were made or should have been made. Thus, the final uncompensated care payment amounts that would be included on a cost report spanning two Federal fiscal years would be the pro rata share of the uncompensated care payment associated with each Federal fiscal year. This pro rata share would be determined based on the proportion of the applicable Federal fiscal year that is included in that cost reporting period. Earlier in this interim final rule with comment period, we reiterated an example from the FY 2014 IPPS/LTCH PPS final rule, where 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 reporting period of January 1, 2014 through December 31, 2014. Under the revised process we are adopting in this interim final rule with comment period, in this example, this hospital would still begin to receive interim payments for its uncompensated care on October 1, 2013. However, instead of having the entire FY 2014 payment reconciled on its cost report for the cost reporting period beginning on January 1, 2014 (which ends on December 31, 2014 and would therefore require the hospital to pay back monies received for the portion of its cost reporting period beginning on January 1, 2013 that occurs in Federal fiscal year 2014), we will reconcile the interim FY 2014 uncompensated care payments received for discharges from October 1, 2013 through December 31, 2013 on the hospital's cost report for the cost reporting period beginning on January 1, 2013 against a pro rata share of its FY 2014 uncompensated care payment. If this hospital is eligible for DSH on its cost report for the cost reporting period ending on December 31, 2013, it will receive a pro rata share of its FY 2014 uncompensated care payment. This pro rata share would be approximately

three-twelfths (that is, the period of time from October 1, 2013 through December 31, 2013, divided by the period of time from January 1, 2013 through December 31, 2013) of the hospital's FY 2014 uncompensated care payment. If the hospital's subsequent cost reporting period is January 1, 2014 through December 31, 2014, we also will reconcile the interim FY 2014 uncompensated care payments received for discharges from January 1, 2014 through September 30, 2014 on the hospital's cost report for the cost reporting period beginning on January 1, 2014 against a pro rata share of its FY 2014 uncompensated care payment. We would also reconcile the interim FY 2015 uncompensated care payments received for discharges from October 1, 2014 through December 31, 2014 (that is, discharges occurring in FY 2015 during that hospital's cost reporting period) on the hospital's cost report for the cost reporting period beginning on January 1, 2014 against a pro rata share of its FY 2015 uncompensated care payment. Accordingly, for the hospital in this example, if it remained eligible for Medicare DSH on its cost report for the cost reporting period beginning on January 1, 2014, it would receive the sum of two pro rata shares of uncompensated care payments, one pro rata share approximately equal to nine-twelfths (that is, the period of time from January 1, 2014 through September 30, 2014 divided by the period of time from January 1, 2014 through December 31, 2014) of the hospital's FY 2014 uncompensated care payment and one pro rata share equal to approximately three-twelfths or (that is, the period of time from October 1, 2014 through December 31, 2014 divided by the period of time from January 1, 2014 through December 31, 2014) of the hospital's FY 2015 uncompensated care payment.

Under this interim final rule with comment period, and in accordance with the policies we finalized in the FY 2014 IPPS/LTCH PPS final rule regarding eligibility for

the uncompensated care payment, hospitals with cost reporting periods that span more than one Federal fiscal year will be eligible for the respective pro rata shares of their uncompensated care payment if they were eligible for DSH in that cost reporting period. If they were ineligible for DSH in that cost reporting period, they would be ineligible to receive the respective pro rata share of the uncompensated care payment for the respective Federal fiscal year (or years). We believe this new approach remains fundamentally consistent with the policy we finalized in the FY 2014 IPPS/LTCH PPS final rule (78 FR 50622) where we stated that “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.” However, it avoids the cost reporting difficulties that would have arisen from the reconciliation process originally adopted in the final rule.

B. Treatment of Indian Health Service Hospitals

In the FY 2014 IPPS/LTCH PPS final rule, we discussed the hospitals that are eligible to receive the uncompensated care payments under section 1886(r)(2) of Act. Specifically, we stated (78 FR 50622) that the “new payment methodology under subsection (r) 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.

In the FY 2014 IPPS/LTCH PPS final rule, we finalized our methodology for calculating the new uncompensated care payments. As we discussed in the final rule,

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. Factor 1 of that methodology 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 pay 25 percent of what would have otherwise been paid under section 1886(d)(5)(F) of the Act. 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.” (See 78 FR 50627).

In the FY 2014 IPPS/LTCH PPS final rule (78 FR 50630), we finalized our proposal to use the most recently available estimates, as calculated by the our Office of the Actuary, to determine both the aggregate amount of empirically justified DSH payments under section 1886(r)(1) of the Act and the aggregate amount of payments that would otherwise have been made under section 1886(d)(5)(F) of the Act. In order to calculate these estimates, our Office of the Actuary used the March 2013 update of the Medicare Hospital Cost Report Information System (HCRIS) and the proposed rule’s IPPS Impact file. The estimate excluded Maryland hospitals, SCHs paid under their hospital-specific rate, and hospitals in the Rural Community Hospital Demonstration Program, as these hospitals do not receive a Medicare DSH payment. The CMS Office of the Actuary’s final estimate for Medicare DSH payments for FY 2014 without regard to the application of section 1886(r)(1) of the Act, is approximately \$12.772 billion. The estimate for empirically justified Medicare DSH payments for FY 2014, with the

application of section 1886(r)(1) of the Act, is approximately \$3.193 billion. Factor 1 is the difference of these two estimates by our Office of the Actuary; therefore, in the FY 2014 IPPS/LTCH PPS final rule, we calculated Factor 1 to be approximately \$9.579 billion.

IHS hospitals are subsection (d) hospitals that can receive empirically justified Medicare DSH payments under section 1886(r)(1) of the Act if they meet the eligibility requirements under subsection (d)(5)(F). Therefore, eligible IHS hospitals will also receive the new uncompensated care payment under subsection (r)(2). However, following the issuance of the FY 2014 IPPS/LTCH PPS final rule, it has come to our attention that although IHS hospitals can receive Medicare DSH payments, they submit Medicare hospital cost reports to CMS that are not uploaded in the HCRIS database. Therefore, their Medicare DSH payments were not included in the estimates by our Office of the Actuary that were used to calculate Factor 1. Because IHS hospitals are eligible to receive Medicare DSH payments and the new uncompensated care payments, we believe it is inappropriate to exclude the Medicare DSH payments to IHS hospitals from the estimates used to calculate Factor 1. In addition, we did not intend to finalize a policy that specifically excludes DSH payments to IHS hospitals from our estimate of Medicare DSH payments for purposes of calculating Factor 1 in the calculation of the uncompensated care payment.

Therefore, in this interim final rule with comment period, we are revising the policy originally adopted in the FY 2014 IPPS/LTCH PPS final rule in order to change the data that will be considered in calculating Factor 1 for FY 2014 and subsequent years. Specifically, in addition to the March 2013 update of HCRIS, we will also consider, supplemental cost report data provided by IHS hospitals to CMS as of March 2013. We

will also recalculate Factor 1, to reflect the Office of the Actuary's estimate of Medicare DSH payments to IHS hospitals, based on this supplemental data. With the inclusion of the Medicare DSH payments to IHS hospitals, our Office of the Actuary's revised estimate of Medicare DSH payments for FY 2014 without regard to the application of 1886(r)(1) of the Act is approximately \$12.791 billion (we note that this revised estimate also includes the correction for Factor 1 made in the correcting document for the FY 2014 IPPS/LTCH PPS final rule that appears elsewhere in this issue of the **Federal Register**). The CMS Office of the Actuary's revised estimate of empirically justified Medicare DSH payments for FY 2014, with the application of section 1886(r)(1) of the Act, is approximately \$3.198 billion (we note that this revised estimate also includes the correction for Factor 1 made in the correcting document for the FY 2014 IPPS/LTCH PPS final rule that appears elsewhere in this issue of the **Federal Register**). Factor 1 is the difference of these two estimates of our Office of the Actuary; therefore, in this interim final rule with comment period, we recalculated Factor 1 to be approximately \$9.593 billion (we note that this revised estimate also includes the correction for Factor 1 made in the correcting document for the FY 2014 IPPS/LTCH PPS final rule that appears elsewhere in this issue of the **Federal Register**). We note that based on the recalculation of Factor 1, the amount available for uncompensated care payments for FY 2014 will be approximately \$9.046 billion (our Factor 2 finalized in the FY 2014 IPPS/LTCH PPS final rule of 0.943 times our revised Factor 1 estimate of \$9.593 billion).

In the FY 2014 IPPS/LTCH PPS final rule (78 FR 50634 through 50643), we discuss the methodology used to calculate Factor 3 in the calculation of the uncompensated care payment. Under the final policy adopted in that final rule, for FY 2014 we would determine a DSH hospital's Factor 3 as the sum of its Medicaid days

and SSI days (numerator) relative to the total number of Medicaid days and SSI days for all DSH hospitals (denominator). Under this policy, we would determine a hospital's SSI days based on the most recent SSI fraction. As we stated in the final rule, the most recent SSI fraction for FY 2014 is the FY 2011 SSI fraction. The FY 2011 SSI fractions for each subsection (d) hospital were published on the CMS website on June 27, 2013. In addition, under the final policy adopted in the final rule, we would determine a hospital's Medicaid days based on the Medicaid days reported on the 2011, or if not available, the 2010 Medicare Hospital Cost Report, using the March 2013 update of HCRIS.

Because the cost reports submitted by IHS hospitals are not uploaded into HCRIS, we did not include their Medicaid days in our calculation of Factor 3. Specifically, Medicaid days for IHS hospitals were excluded from the numerator of Factor 3 for those IHS hospitals and from the denominator of Factor 3 for all hospitals. As a result, we believe that the Factor 3 that was calculated for each IHS hospital under the policies adopted in the 2014 IPPS/LTCH PPS final rule, based only on FY 2011 SSI days, significantly understated the actual amount of uncompensated care furnished by these hospitals. The uncompensated care payment amounts calculated for these hospitals were also significantly lower than they would have been had these days been included. We are concerned that under the policy originally adopted in the FY 2014 IPPS/LTCH PPS final rule, IHS hospitals, that serve a significant low income population, will be subject to the 75 percent reduction to their Medicare DSH payments under subsection (r)(1) but will receive reduced uncompensated care payments under subsection (r)(2) due to their cost reports not being included in the HCRIS database. Given that we intended to base our estimate of the uncompensated care provided by IHS hospitals, in part, on the care they provide to Medicaid patients, we believe it is appropriate to make a change to the data

that will be considered in determining Factor 3 of the new uncompensated care payment to allow the Medicaid days for IHS hospitals to be included. This change will also help to ensure that eligible IHS hospitals receive an uncompensated care payment that does not significantly understate the amount of uncompensated care they provide.

Accordingly, in this interim final rule with comment period, we are revising the policy adopted in the final rule to permit us to consider supplemental cost report data submitted to CMS as of March 2013 only by IHS hospitals in addition to data reflected in the March 2013 update of HCRIS, in calculating Factor 3 of the uncompensated care payment. The Medicaid days for IHS hospitals that are reflected in the supplemental data will be included in the numerator of the Factor 3 calculation for IHS hospitals and will be included in the denominator of Factor 3 for all hospitals eligible to receive the uncompensated care payment.

III. Waiver of Proposed Rulemaking and Delay in Effective Date

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** and invite public comment on the proposed rule in accordance with 5 U.S.C. 553(b) of the Administrative Procedure Act (APA). The notice of proposed rulemaking includes a reference to the legal authority under which the rule is proposed, and the provisions of the proposed rule or a description of the subjects and issues involved. This procedure can be waived, however, if an agency finds good cause that a notice-and-comment procedure is impracticable, unnecessary, or contrary to the public interest and incorporates a statement of the finding and its reasons in the rule issued.

We believe there is good cause to waive notice and comment rulemaking to make the revisions to our policy for reconciling uncompensated care payments for hospitals with Medicare cost reporting periods that are not concurrent with the Federal fiscal year.

We believe it would be inequitable and contrary to the public interest to require the large majority of IPPS hospitals that have a cost reporting period that does not align with the Federal fiscal year to pay back to CMS the monies they receive as interim uncompensated care payments for Federal FY 2014 during their cost reporting period beginning in Federal FY 2013. Additionally, these hospitals would experience a delay in the receipt of their final Federal FY 2014 uncompensated care payments until their next cost reporting period. This change will not affect the manner in which uncompensated care payments are calculated. Rather, it affects only the manner in which those payments are reconciled for cost reporting purposes. As a result, the policy being adopted in this interim final rule with comment period will benefit those hospitals that have cost reporting periods that do not align with the Federal fiscal year by avoiding administrative issues. These administrative issues would effectively delay uncompensated care payments, frustrate our policy of making uncompensated care payments promptly, and would likely lead to serious cash flow difficulties for some hospitals. There will be no impact on hospitals that have cost reporting periods that align with the Federal fiscal year. Therefore, we believe it would be contrary to the public interest not to change the methodology for reconciling uncompensated care payments for hospitals that have cost reporting periods that are not concurrent with the Federal fiscal year. Further, it would be impracticable to go through notice-and-comment rulemaking to achieve what we believe would be the more equitable and efficient result. The methodology for reconciling uncompensated care payments adopted in the FY 2014 IPPS/LTCH PPS final rule goes into effect on October 1, 2013. There is insufficient time to undertake notice-and-comment rulemaking before that date. As a result, absent this interim final rule with comment period, it would be impossible to avoid the administrative issues discussed

previously.

We also believe there is good cause to waive notice-and-comment rulemaking to make changes to the data that will be used in the uncompensated care payment calculation in order to ensure that data from IHS hospitals are included in Factor 1 and Factor 3 of that calculation. As discussed previously, IHS hospitals are subsection (d) hospitals that can receive Medicare DSH payments and uncompensated care payments. However, IHS hospitals submit Medicare Hospital Cost reports to CMS that are not uploaded into the HCRIS database. As a result, the data for these hospitals were excluded from the estimates for Factor 1, which were based upon data from the March 2013 update of HCRIS. In addition, the Medicaid days for IHS hospitals were excluded from the calculation of Factor 3. Specifically, these Medicaid days were excluded from the numerator for the IHS hospitals and excluded from the denominator for all hospitals. As a result, the Factor 3 that was calculated for each IHS hospital under the policy adopted in the FY 2014 IPPS/LTCH PPS final rule is understated and will result in reduced uncompensated care payments to these hospitals.

We believe it is contrary to the public interest not to correct this inadvertent oversight by supplementing the data used to calculate Factor 1 and Factor 3 to reflect cost report data submitted to CMS by IHS hospitals. As discussed previously, IHS hospitals are subsection (d) hospitals that may receive DSH payments if all other eligibility criteria are satisfied. Pursuant to section 1886(r)(1) of the Act, starting on October 1, 2013, DSH payments to all hospitals that are eligible for DSH, including IHS hospitals, will be reduced by 75 percent. As a result, we believe it is important that Factor 1 of the uncompensated care calculation incorporates the amount by which DSH payments to IHS hospitals will be reduced as a result of the implementation of section 1886(r)(1) of the

Act. Furthermore, we believe it is in the public interest to ensure that our estimate of the amount of uncompensated care for IHS hospitals for purposes of determining Factor 3 of the uncompensated care payment calculation takes into account care provided to Medicaid patients. IHS hospitals serve a significant low income population, including individuals that are eligible for Medicaid. It was not our intention to exclude the care furnished by IHS hospitals to Medicaid eligible individuals, and thus to understate the amount of Factor 3 for these hospitals. Rather, this was an inadvertent error that arose from the data that we originally elected to use for the purposes of determining the uncompensated care payments. Nevertheless, this omission results in a significant reduction in the uncompensated care payments received by IHS hospitals. We believe it would be contrary to the public interest not to address that inadvertent omission by supplementing the data originally used in the FY 2014 IPPS/LTCH PPS final rule to include data that reflects the Medicaid days for IHS hospitals for a time period that is contemporaneous with the time period of the data used to estimate uncompensated care for other subsection (d) hospitals. Further, for the same reasons stated previously, it would be impracticable to go through notice-and-comment rulemaking to achieve what we believe would be the more equitable result. The FY 2014 IPPS/LTCH PPS final rule goes into effect on October 1, 2013. There is insufficient time to undertake notice-and-comment rulemaking before that date. As a result, absent this interim final rule with comment period, it would not be possible to recompute Factor 1 and Factor 3 of the uncompensated care payment methodology before the start of the fiscal year, and uncompensated care payments to IHS hospitals would significantly understate their relative share of the total uncompensated care burden.

For all of these reasons, we find good cause to waive the notice-and-comment

rulemaking procedure for this interim final rule with comment period.

In addition, section 553(d) of the APA (5 U.S.C. 553(d)) ordinarily requires a 30-day delay in the effective date of final rules after the date of their publication in the **Federal Register**. This 30-day delay in effective date can be waived, however, if an agency finds for good cause that the delay is impracticable, unnecessary, or contrary to the public interest, and the agency incorporates a statement of the finding and its reasons in the rule issued.

As described previously, the process that we adopted in the FY 2014 IPPS/LTCH PPS final rule for reconciling uncompensated care payments would result in the large majority of IPPS hospitals that do not have cost reporting periods concurrent with the Federal fiscal year being required to pay back to CMS the monies they receive as interim uncompensated care payments during Federal fiscal year 2014 for the portion of their cost reporting period beginning in Federal FY 2013 and experiencing a delay in the receipt of their final FY 2014 uncompensated care payments until their next cost reporting period. If we were to provide for a 30-day delay in the effective date of this provision, hospitals with 2014 cost reporting periods that begin after October 1, 2013, but before this interim final rule with comment period becomes effective would be adversely affected as we described previously. Therefore, we believe it is contrary to the public interest to delay the effective date of revising this process.

Similarly, as described previously, the data used to calculate Factor 1 and Factor 3 did not include data from the Medicare Hospital Cost Reports for IHS hospitals. This omission resulted in our estimate of Factor 1 of the uncompensated care payment being understated. In addition, Factor 3, which is used to determine each hospital's share of uncompensated care payment amounts, was understated for IHS hospitals because it

excluded all Medicaid days for those hospitals, which are a significant portion of the uncompensated care they provide. If we were to provide for a 30-day delay in the effective date of this interim final rule with comment period, we believe the exclusion of this data from our calculation of uncompensated care payments would pose a financial hardship for IHS hospitals that serve a significant low income patient population. Therefore, we believe it is contrary to the public interest to delay the effective date of this revision to our methodology to allow the use of supplemental data submitted by IHS hospitals.

For all of these reasons, we find good cause to waive the 30-day delay in the effective date for this interim final rule with comment period.

IV. Collection of Information Requirements

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

V. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the "DATES" section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

VI. Regulatory Impact Statement

We have examined the impact of this rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), the Regulatory

Flexibility Act (RFA) (September 19, 1980, Pub. L. 96-354), section 1102(b) of the Social Security Act, section 202 of the Unfunded Mandates Reform Act of 1995 (March 22, 1995, Pub. L. 104-4), Executive Order 13132 on Federalism (August 4, 1999) and the Congressional Review Act (5 U.S.C. 804(2)).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). Executive Order 13563 emphasizes the importance of quantifying both costs and benefits, of reducing costs, of harmonizing rules, and of promoting flexibility. A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects (\$100 million or more in any 1 year). The monetary impact of this final rule is approximately a \$15 million increase in payments to hospitals relative to the estimates included in the FY 2014 IPPS/LTCH PPS final rule. Therefore, this interim final rule with comment period does not reach the economic threshold and thus is not considered a major rule.

The RFA requires agencies to analyze options for regulatory relief of small entities if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of less than \$7.0 million to \$35.5 million in any 1 year. Individuals and States are not included in the definition of a small entity. For purposes of the RFA, all hospitals and other providers and suppliers are considered to be small entities. Individuals and States are not included in the definition of a small entity. We believe that this interim final rule with comment

period will have an impact on small entities.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. With the exception of hospitals located in certain New England counties, for purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside a metropolitan statistical area and has fewer than 100 beds.

Section 601(g) of the Social Security Amendments of 1983 (Pub. L. 98-21) designated hospitals in certain New England counties as belonging to the adjacent urban area. Thus, for purposes of the IPPS and the LTCH PPS, we continue to classify these hospitals as urban hospitals. (We refer readers to Table I in section I.G. of the Appendix for the FY 2014 IPPS/LTCH PPS final rule for the quantitative effects of the final policy changes under the IPPS for operating costs.)

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of \$100 million in 1995 dollars, updated annually for inflation. In 2013, that threshold is approximately \$141 million. This interim final rule with comment period will have no consequential effect on State, local, or tribal governments, nor will it affect private sector costs.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a final rule that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. Since this regulation does not impose any costs on State or local governments, the requirements of Executive Order 13132 are not applicable.

In accordance with the provisions of Executive Order 12866, this rule was not reviewed by the Office of Management and Budget.

CMS-1599-IFC

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

Dated: September 27, 2013

Marilyn Tavenner,

Administrator,

Centers for Medicare & Medicaid Services.

Approved: September 27, 2013

Kathleen Sebelius,

Secretary,

Department of Health and Human Services.

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