2015, they must have a CMI value for FY 2014 that is at least—

- 1.6075; or
- The median CMI value (not transfer-adjusted) for urban hospitals (excluding hospitals with approved teaching programs as identified in § 413.75) calculated by CMS for the census region in which the hospital is located. (We refer readers to the table set forth in the FY 2016 IPPS/LTCH PPS proposed rule at 80 FR 24480.)

The final CMI values for FY 2016 are based on the latest available data (FY 2014 bills received through March 2015). In addition to meeting other criteria, if rural hospitals with fewer than 275 beds are to qualify for initial RRC status for cost reporting periods beginning on or after October 1, 2015, they must have a CMI value for FY 2014 that is at least—

- 1.6082; or
- The median CMI value (not transfer-adjusted) for urban hospitals (excluding hospitals with approved teaching programs as identified in § 413.75) calculated by CMS for the census region in which the hospital is located.

The final median CMI values by region are set forth in the following table.

Region	Case-mix index value
1. New England (CT, ME, MA, NH, RI, VT)	1.3737
2. Middle Atlantic (PA, NJ, NY)	1.4500
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	1.5035
4. East North Central (IL, IN, MI, OH, WI)	1.5104
5. East South Central (AL, KY, MS, TN)	1.4184
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	1.5855
7. West South Central (AR, LA, OK, TX)	1.6276
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	1.7075
9. Pacific (AK, CA, HI, OR, WA)	1.6168

A hospital seeking to qualify as an RRC should obtain its hospital-specific CMI value (not transfer-adjusted) from its MAC. Data are available on the Provider Statistical and Reimbursement (PS&R) System. In keeping with our policy on discharges, the CMI values are computed based on all Medicare patient discharges subject to the IPPS MS–DRG-based payment.

2. Discharges

Section 412.96(c)(2)(i) provides that CMS set forth the national and regional numbers of discharges criteria in each year's annual notice of prospective payment rates for purposes of determining RRC status. As specified in section 1886(d)(5)(C)(ii) of the Act, the national standard is set at 5,000 discharges. In the FY 2016 IPPS/LTCH PPS proposed rule (80 FR 24480), for FY 2016, we proposed to update the regional standards based on discharges for urban hospitals' cost reporting periods that began during FY 2013 (that is, October 1, 2012 through September 30, 2013), which are the latest cost report data available at the time the proposed rule was developed.

We proposed that, in addition to meeting other criteria, a hospital, if it is to qualify for initial RRC status for cost reporting periods beginning on or after October 1, 2015, must have, as the number of discharges for its cost reporting period that began during FY 2013, at least—

- 5,000 (3,000 for an osteopathic hospital); or
- The median number of discharges for urban hospitals in the census region in which the hospital is located. (We refer readers to the table set forth in the FY 2016 IPPS/LTCH PPS proposed rule at 80 FR 24480.)

Based on the latest discharge data available at this time (that is, based on FY 2013 cost report data), the final median number of discharges for urban hospitals by census region are set forth in the following table.

Region	Number of discharges
1. New England (CT, ME, MA, NH, RI, VT)	7,462
2. Middle Atlantic (PA, NJ, NY)	10,594
3. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	10,233
4. East North Central (IL, IN, MI, OH, WI)	7,992
5. East South Central (AL, KY, MS, TN)	7,672
6. West North Central (IA, KS, MN, MO, NE, ND, SD)	7,857
7. West South Central (AR, LA, OK, TX)	5,490
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	8,046
9. Pacific (AK, CA, HI, OR, WA)	8,797

We note that the median number of discharges for hospitals in each census region is greater than the national standard of 5,000 discharges. Therefore, under this final rule, 5,000 discharges is the minimum criterion for all hospitals, except for osteopathic hospitals for which the minimum criterion is 3,000 discharges.

C. Indirect Medical Education (IME) Payment Adjustment Factor for FY 2016 (§ 412.105)

Under the IPPS, an additional payment amount is made to hospitals with 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)(ii)(XII) of the Act provides that, for discharges occurring during FY 2008 and fiscal years thereafter, the IME formula multiplier is 1.35. Accordingly, for discharges occurring during FY 2016, the formula multiplier is 1.35. We estimate that application of this formula multiplier for the FY 2016 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.

We did not receive any public comments on this provision. As noted above, the IME formula multiplier is specified in statute and is 1.35 for FY 2016.

D. FY 2016 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. Impact on Medicare DSH Payment Adjustment of the Continued Implementation of New OMB Labor Market Area Delineations

As discussed in section III.G. of the preamble of this final rule, in the FY 2015 IPPS/LTCH PPS final rule (79 FR 49951) we implemented the revised OMB labor market area delineations (which are based on 2010 Decennial Census data) for the FY 2015 wage index. (In this final rule, we refer to these revised OMB labor market area delineations as the ''new OMB delineations.'') We stated that this implementation would have an impact on the calculation of Medicare DSH payments to certain hospitals. Hospitals that are designated as rural with less than 500 beds and that are not rural referral centers (RRCs) are subject to a maximum DSH payment adjustment of 12 percent. Accordingly, hospitals with less than 500 beds that were in urban counties that became rural when we adopted the new OMB delineations, and that did not become RRCs, are subject to a maximum DSH payment adjustment of 12 percent. (We note that urban hospitals are only subject to a maximum DSH payment adjustment of 12 percent if they have less than 100 beds.)

Under the regulation at 42 CFR 412.102, a hospital located in an area that is reclassified from urban to rural, as defined in the regulations, may receive an adjustment to its rural Federal payment amount for operating costs for 2 successive fiscal years. Specifically, the regulations state that, in the first year after a hospital loses urban status, the hospital will receive an additional payment that equals two-thirds of the difference between the DSH payments as applicable to the hospital before its redesignation from urban to rural and the DSH payments applicable to the hospital subsequent to its redesignation from urban to rural. In the second year after a hospital loses urban status, the hospital will receive an additional payment that equals one-third of the difference between the DSH payments applicable to the hospital before its redesignation from urban to rural and the DSH payments otherwise applicable to the hospital subsequent to its redesignation from urban to rural.

For the purposes of ratesetting, calculating budget neutrality, and modeling payment impacts for this FY 2016 final rule, for any hospital that was previously urban but changed to rural status in FY 2015 as a result of the adoption of the new OMB labor market area delineations, in the FY 2016 IPPS/LTCH PPS proposed rule, we proposed to model its DSH payments such that the payment equals the amount of the rural DSH payments plus one-third of the difference between the urban DSH payments and the rural DSH payments.

We did not receive any public comments on our proposal.

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

a. General Discussion

Section 3133 of the Patient Protection and Affordable Care Act, as amended by section 10316 of the same Act 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 final rule, we refer to these provisions collectively as section 3133 of the Affordable Care Act.

Medicare DSH 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 with discharges in FY 2014, hospitals that qualify for Medicare DSH payments under section 1886(d)(5)(F) of the Act receive 25 percent of the amount they previously would have received under the statutory formula for Medicare DSH payments. This provision applies equally to hospitals that qualify for DSH payments under section 1886(d)(5)(F)(i)(I) of the Act and those hospitals that qualify under the Pickle method under section 1886(d)(5)(F)(i)(II) of the Act.

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, is 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 are 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.

As provided by section 3133 of the Affordable Care Act, section 1886(r) of the Act requires that, for FY 2014 and each subsequent fiscal year, a subsection (d) hospital that would otherwise receive a disproportionate share hospital payment made under section 1886(d)(5)(F) of the Act receives 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 DSH 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 empirically justified Medicare DSH payment, section 1886(r)(2) of the Act provides that, for FY 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 section 1886(d)(5)(F) of the Act if

subsection (r) did not apply and the aggregate amount of payments that are made to subsection (d) hospitals under section 1886(r)(1) of the Act 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 Director of the Congressional Budget Office to the Speaker of the House. (The March 20, 2010 letter is available for viewing on the following Web site: *http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/113xx/doc11379/amendreconprop.pdf*.)

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 the percent of individuals who are uninsured in the most recent period for which data are available (as so estimated and certified), minus 0.2 percentage point for FYs 2018 and 2019. Therefore, for FY 2018 and subsequent years, the statute provides some greater flexibility in the choice of the data sources to be used for the estimate of the change in the percent of uninsured individuals.

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 section 1886(r) of the Act. 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 applies to FY 2014 and each subsequent fiscal year. In the FY 2014 IPPS/LTCH PPS final rule (78 FR 50620 through 50647) and the FY 2014 IPPS interim final rule with comment period (78 FR 61191 through 61197), we set forth our policies for implementing the required changes to the DSH payment methodology made by section 3133 of the Affordable Care Act for FY 2014. In those rules, we noted that, because section 1886(r) of the Act 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 section 1886(r)(2) of the Act or of any period selected by the Secretary for the purpose of determining those factors. Therefore, there is 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 for Empirically Justified Medicare DSH Payments and Uncompensated Care Payments

As indicated earlier, the payment methodology under section 3133 of the Affordable Care Act applies to ''subsection (d) hospitals'' that would otherwise receive a DSH payment made under section 1886(d)(5)(F) of the Act. Therefore, hospitals must receive empirically justified Medicare DSH payments in a fiscal year in order to receive an additional Medicare uncompensated care payment for that year. Specifically, section 1886(r)(2) of the Act states that, in addition to the payment made to a subsection (d) hospital under section 1886(r)(1) of the Act, the Secretary shall pay to *such subsection (d) hospitals* an additional amount. Because section 1886(r)(1) of the Act refers to empirically justified Medicare DSH payments, the additional payment under section 1886(r)(2) of the Act is limited to hospitals that receive empirically justified Medicare DSH payments in accordance with section 1886(r)(1) of the Act for the applicable fiscal year.

In the FY 2014 IPPS/LTCH PPS final rule (78 FR 50622) and the FY 2014 IPPS interim final rule with comment period (78 FR 61193), we provided that hospitals that are not eligible to receive empirically justified Medicare DSH payments in a fiscal year will not receive uncompensated care payments for that year. We also specified that we would make a determination concerning eligibility for interim uncompensated care payments based on each hospital's estimated DSH status for the applicable fiscal year (using the most recent data that are available). We indicated that our final determination on the hospital's eligibility for uncompensated care payments would be based on the hospital's actual DSH status at cost report settlement for that payment year.

In the FY 2014 IPPS/LTCH PPS final rule (78 FR 50622) and the FY 2015 IPPS/LTCH PPS final rule (79 FR 50006), we specified our policies for several specific classes of hospitals within the scope of section 1886(r) of the Act. We refer readers to those two final rules for a detailed discussion of our policies. In summary, we specified the following:

- *Subsection (d) Puerto Rico hospitals* that are eligible for DSH payments also are eligible to receive empirically justified Medicare DSH payments and uncompensated care payments under the new payment methodology (78 FR 50623 and 79 FR 50006).
- *Maryland hospitals* are not eligible to receive empirically justified Medicare DSH payments and uncompensated care payments under the payment methodology of section 1886(r) of the Act because they are not paid under the IPPS. As discussed in the FY 2015 IPPS/LTCH PPS final rule (79 FR 50007),

effective January 1, 2014, the State of Maryland elected to no longer have Medicare pay Maryland hospitals in accordance with section 1814(b)(3) of the Act and entered into an agreement with CMS that Maryland hospitals will be paid under the Maryland All-Payer Model. However, under the Maryland All-Payer Model, Maryland hospitals still are not paid under the IPPS. Therefore, they remain ineligible to receive empirically justified Medicare DSH payments or uncompensated care payments under section 1886(r) of the Act.

- *SCHs* that are paid under their hospital-specified rate are not eligible for Medicare DSH payments. SCHs that are paid under the IPPS Federal rate receive interim payments 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, and if they receive interim empirically justified Medicare DSH payments in a fiscal year, they also will receive interim uncompensated care payments for that fiscal year on a per discharge basis, subject as well to settlement through the cost report. Final eligibility determinations will be made at the end of the cost reporting period at settlement, and both interim empirically justified Medicare DSH payments and uncompensated care payments will be adjusted accordingly (78 FR 50624 and 79 FR 50007).
- *MDHs* are paid based on the IPPS Federal rate or, if higher, the IPPS Federal rate plus 75 percent of the amount by which the Federal rate is exceeded by the updated hospital-specific rate from certain specified base years (76 FR 51684). The IPPS Federal rate used in the MDH payment methodology is the same IPPS Federal rate that is used in the SCH payment methodology. We note that at the time of the development of the FY 2016 IPPS/LTCH PPS proposed rule, the MDH Program was to be in effect for discharges on or before March 31, 2015, only. Section 205 of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), Public Law 114–10, enacted April 16, 2015, extended the MDH program for discharges on or after April 1, 2015, through September 30, 2017. (We refer readers to the interim final rule with comment period at section IV.L.3. of the preamble of this document for a full discussion of the extension of the MDH Program.) Because MDHs are paid based on the IPPS Federal rate, for FY 2016, MDHs will continue to be eligible to receive Medicare DSH payments and uncompensated care payments if their disproportionate patient percentage is at least 15 percent. We will apply the same process to determine MDH eligibility for Medicare DSH and uncompensated care payments, as we do for all other IPPS hospitals, through September 30, 2017. Moreover, we will continue to make a determination concerning eligibility for interim uncompensated care payments based on each hospital's estimated DSH status for the applicable fiscal year (using the most recent data that are available). Our final determination on the hospital's eligibility for uncompensated care payments will be based on the hospital's actual DSH status at cost report settlement for that payment year. In addition, as we do for all IPPS hospitals, we calculate a numerator for Factor 3 for all MDHs, regardless of whether they are projected to be eligible for Medicare DSH payments during the fiscal year, but the denominator for Factor 3 will be based on the uncompensated care data from the hospitals that we have projected to be eligible for Medicare DSH payments during the fiscal year.
- *IPPS hospitals that have elected to participate in the Bundled Payments for Care Improvement initiative* continue to be paid under the IPPS (77 FR 53342) and, therefore, are eligible to receive empirically justified Medicare DSH payments and uncompensated care payments (78 FR 50625 and 79 FR 50008).
- *Hospitals participating in the Rural Community Hospital Demonstration Program* under section 410A of the Medicare Modernization Act do not receive DSH payments and, therefore, are excluded from receiving empirically justified Medicare DSH payments and uncompensated care payments under the new DSH payment methodology (78 FR 50625 and 79 FR 50008). There are 17 hospitals currently participating in the demonstration.

c. Empirically Justified Medicare DSH Payments

As we have discussed earlier, section 1886(r)(1) of the Act requires the Secretary to pay 25 percent of the amount of the DSH payment that would otherwise be made under section 1886(d)(5)(F) of the Act to a subsection (d) hospital. 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 stated in the FY 2014 IPPS/LTCH PPS final rule that we did not believe that it was necessary to develop any new operational mechanisms for making such payments. Therefore, in the FY 2014 IPPS/LTCH PPS final rule (78 FR 50626), we implemented this provision by advising MACs to simply adjust the interim claim payments to the requisite 25 percent of what would have otherwise been paid. We also made 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 provided more detailed operational instructions and cost report instructions following issuance of the FY 2014 IPPS/LTCH PPS final rule that are available on the CMS Web site at: *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2014-Transmittals-Items/R5P240.html*.

d. Uncompensated Care Payments

As we have discussed earlier, section 1886(r)(2) of the Act provides that, for each eligible hospital in FY 2014 and subsequent years, the 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 the rate of uninsurance in 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 data sources and methodologies for computing each of these factors, our final policies for FY 2014 and FY 2015, and our proposed and final policies for FY 2016.

(1) Calculation of Factor 1 for FY 2016

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 section 1886(d)(5)(F) if this section 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 section 1886(r)(1) of the Act for such 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 under section 1886(d)(5)(F) of the Act if section 1886(r) of the Act did not apply for such fiscal year. 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, section 1886(r)(2)(A)(i) of the Act provides 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 a fiscal year, as prescribed under section 1886(r)(1) of the Act. Again, section 1886(r)(2)(A)(ii) of the Act provides 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 the fiscal year, in the absence of the new payment provision; and (2) the amount of empirically justified Medicare DSH payments that are made for the fiscal year, 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 the fiscal year.

As we did for FY 2015, in order to determine Factor 1 in the uncompensated care payment formula for FY 2016, in the FY 2016 IPPS/LTCH PPS proposed rule (80 FR 24484), we proposed to continue the policy established in the FY 2014 IPPS/LTCH PPS final rule (78 FR 50628 through 50630) and in the FY 2014 IPPS interim final rule with comment period (78 FR 61194). Under this policy, Factor 1 is determined by developing estimates of both the aggregate amount of Medicare DSH payments that would be made in the absence of section 1886(r)(1) of the Act and the aggregate amount of empirically justified Medicare DSH payments to hospitals under section 1886(r)(1) of the Act through rulemaking. These estimates will not be revised or updated after we know the final Medicare DSH payments for FY 2016.

Therefore, in order to determine the two elements of Factor 1 (Medicare DSH payments *prior* to the application of section 1886(r)(1) of the Act, and empirically justified Medicare DSH payments *after* application of section 1886(r)(1) of the Act), in FYs 2014 and 2015, we used the most recently available projections of Medicare DSH payments for the applicable fiscal year, as calculated by CMS' Office of the Actuary using 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.

For purposes of calculating Factor 1 and modeling the impact of this provision for the FY 2016 IPPS/LTCH PPS proposed rule (80 FR 24484), we used the Office of the Actuary's February 2015 Medicare DSH estimates, which are based on data from the December 2014 update of the Medicare Hospital Cost Report Information System (HCRIS), 2012 cost report data provided to CMS by IHS hospitals, and the FY 2015 IPPS/LTCH PPS final rule IPPS Impact File, published in conjunction with the publication of the FY 2015 IPPS/LTCH PPS final rule. Because SCHs that are projected to be paid under their hospital-specific rate are not subject to the provisions of section 1886(r) of the Act, these hospitals were excluded from the February 2015 Medicare DSH estimates. Furthermore, because section 1886(r) of the Act specifies that the uncompensated care payment is in addition to the empirically justified DSH payment (or 25 percent of DSH payments that would be made without regard to section 1886(r)), Maryland hospitals participating in the Maryland All-Payer Model and hospitals participating in the Rural Community Hospital Demonstration that do not receive DSH payments also are excluded from the Office of the Actuary's Medicare DSH estimates.

Using the data sources discussed above, the Office of the Actuary 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 2015 Office of the Actuary estimate for proposed Medicare DSH payments for FY 2016, without regard to the application of section 1886(r)(1) of the Act, was approximately $13.338 billion. Therefore, based on the February 2015 estimate, the estimate for empirically justified Medicare DSH payments for FY 2016, with the application of section 1886(r)(1) of the Act, was $3.335 billion (25 percent of the total amount estimated). Under § 412.106(g)(1)(i) of the regulations, Factor 1 is the difference between these two estimates of the Office of the Actuary. Therefore, in the proposed rule, we proposed that Factor 1 for FY 2016 would be $10,003,425,327.39 ($13,337,900,436.52 minus $3,334,475,109.13). We invited public comments on our proposed calculation of Factor 1 for FY 2016.

Comment: A number of commenters supported CMS' methodology for determining Factor 1 and the proposed Factor 1 for FY 2016.

Response: We appreciate the commenters' support.

Comment: A number of commenters asked for greater transparency around the methodology used by the Office of the Actuary to estimate aggregate DSH payments that would have been paid absent implementation of the Affordable Care Act, particularly transparency in the calculation of estimated DSH payments for purposes of Factor 1. The commenters urged CMS to clarify the methodology used to make these projections and to provide additional information related to them. The commenters also requested that this information be provided in advance of publication of the IPPS final rule and, in the future, in proposed rules each year. The commenters stated that hospitals do not have sufficient information to understand or replicate the relevant projections and estimates for Factor 1.

Many commenters highlighted that one of the assumptions (the assumption shown in ''Other'' column) used in determining the proposed Factor 1 for FY 2016 has a substantial negative effect on hospitals, and requested more explanation for that assumption as well as a reassessment of the assumption. They pointed out that this assumption had previously, according to CMS, included the impact of only IPPS discharges and the impact of DSH payments increasing or decreasing at a different rate than other IPPS payments. The commenters expressed concern that the ''Other'' column changed from 1.0355 in the FY 2015 IPPS/LTCH PPS final rule to 0.9993 in the FY 2016 IPPS/LTCH PPS proposed rule. The commenters noted that the explanation offered in the FY 2015 IPPS/LTCH PPS final rule discussed Medicaid enrollment and utilization patterns and that this did not appear to explain the change in the variable in the FY 2016 IPPS/LTCH PPS proposed rule. Some commenters pointed out that, to some extent, the ''Other'' assumption is affected by the ''Discharge'' assumption, and that they believed discharges are decreasing faster than what was taken into consideration in the FY 2015 IPPS/LTCH PPS final rule. In other words, they believed that the trend information used to determine the ''Discharge'' assumption may be resulting in a lower number for the ''Other'' assumption.

One commenter stated that CMS does not disclose how discharge data are adjusted by a completion factor. One commenter also pointed out that the values for the assumptions regarding discharges and case-mix across FY 2014, FY 2015, and FY 2016 are relatively similar, while the value for the ''Other'' assumption has changed. The commenters requested that CMS also share detailed calculations of the discharge and case-mix values.

Several commenters believed that the ''Other'' assumption should reflect the changes in DSH payments that would result from the Medicaid and CHIP expansion. Other commenters asked CMS to explain how the Medicaid and CHIP expansion is accounted for in the Factor 1 estimate. The commenters stated that the additional Medicaid and CHIP enrollment estimated for 2014 through 2016 by CBO in a February 2014 report represents a 32-percent increase in this population. The commenters stated that they had reviewed other data, including the ASPE Issue Brief entitled ''Impact of Insurance Expansion on Hospital Uncompensated Care Costs in 2014,'' that indicate that Medicaid enrollment and utilization have increased. The commenters believed that Factor 1 is too low because it does not take this increase into consideration appropriately. They noted that CMS has responded to similar comments in prior rulemaking by stating that ''the increase due to Medicaid expansion is not as large as commenters contended due to the actuarial assumption that the new enrollees are healthier than the average Medicaid recipient, and, therefore, use fewer hospital services.'' However, the commenters asserted that CMS provided no support for this contention and that CMS should have enrollment and/or utilization information from Medicaid expansion programs. Furthermore, the commenters stated that they believed CMS did not take into consideration any one-time increase in utilization resulting from the new Medicaid enrollment and the previously unmet health care needs of that population. These commenters believed that, in the early years of Medicaid expansion, such an increase in utilization would be more logical than CMS' assertion that new Medicaid enrollees would use fewer hospital services.

Several commenters believed that it would be appropriate to adjust the ''Other'' assumption in a manner that supports safety-net hospitals in order to reflect the growing number of hospitals that are becoming eligible for DSH. Based on this belief, the commenters expressed concern about the sustainability of continued reductions to aggregate uncompensated care payments. The commenters noted that, as insurance coverage increases, the aggregate amount available for uncompensated care payments will decline and thus reduce the amount of payments to be distributed to help cover the cost of uncompensated care. The commenters further noted that hospitals in States that have not expanded Medicaid are not experiencing a decrease in uncompensated care costs and that reductions in Medicare DSH payments are detrimental to these hospitals. Some commenters noted the reductions in payments they would experience due to CMS' uncompensated care proposal in totality.

Several commenters believed there was incomplete information in the FY 2016 IPPS/LTCH PPS proposed rule regarding the ''completion factor'' and requested further detail. One commenter believed that the growth rates in DSH payments are higher than the current data indicate because the completion factor for the cost reports in HCRIS for 2012 and 2013 is low. Specifically, the commenter shared an analysis that showed that approximately one-half of the 2012 cost reports contained adjusted Medicaid days data and approximately one-fifth of the 2013 cost reports contained adjusted Medicaid days data. The commenter showed the results of a longitudinal analysis between December 2012 and March 2015 using HCRIS data that demonstrated that Medicaid days increased between when 2010, 2011, and 2012 cost reports were filed and March 2015, regardless of the status of the cost report settlement process (for example, amended, reopened, settled without audit, or settled with audit). The range of increase shown by the commenter's analysis was between 0.3 percent and 3.7 percent. The commenter stated that in its longitudinal analysis of HCRIS data between December 2012 and March 2015, it further examined DSH payments reported in HCRIS and found that payments increased on average 1.1 percent over the 2-year period.

One commenter requested that CMS use the most recent 2012 cost report data in its estimate of Factor 1. The commenter stated that problems in obtaining accurate data for Medicaid days can lead to underreporting in the initial submission of the Medicare cost report and that this delay can also affect the DSH payment calculated in the cost report. Therefore, the commenter requested that CMS revise its estimate of the 2012 DSH payments in the final rule using the latest available update of the 2012 Medicare cost report data.

Commenters wanted to better understand the changes in the estimate of aggregate DSH payments that would have been paid absent implementation of the Affordable Care Act over time and wanted to be able to replicate the figures. The commenters believed that transparency is critical because the statute precludes judicial review of the estimates for purposes of determining the three factors used in computing uncompensated care payments and because they understand that these estimates will not be revised or updated after the final rule.

Response: Factor 1 is not estimated in isolation. The Factor 1 estimates for proposed rules are generally consistent with the economic assumptions and actuarial analysis used to develop the President's Budget estimates under current law, and the Factor 1 estimates for the final rule are generally consistent with those used for the Mid-Session Review of the President's Budget. For additional information on the development of the President's Budget, we refer readers to the Office of Management and Budget Web site at: *https://www.whitehouse.gov/omb/budget*. For additional information on the specific economic assumptions used in the Midsession Review of the President's FY 2016 Budget, we refer readers to the ''Midsession Review of the President's FY 2016 Budget'' available on the Office of Management and Budget Web site at: *https://www.whitehouse.gov/sites/default/files/omb/budget/fy2016/assets/16msr.pdf*, under ''Economic Assumptions''. For a general overview of the principal steps involved in projecting future inpatient costs and utilization, we refer readers to the ''2014 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds'' available on the CMS Web site at: *http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/downloads/tr2014.pdf* under ''Actuarial Methodology and Principal Assumptions for Cost Estimates''.

As we did in the FY 2015 IPPS/LTCH PPS final rule (79 FR 50010), later in this section we provide additional information regarding the data sources, methods, and assumptions employed by the actuaries in determining the Office of the Actuary's updated estimate of Factor 1 for FY 2016. We believe that this discussion addresses the methodological concerns raised by commenters regarding the various assumptions used in the estimate, including the ''Other'' and ''Discharges'' assumptions and also provides

additional information regarding how we address the Medicaid and CHIP expansion. However, we note that, with regard to the commenters' questions and concerns on the completion factor for 2012 and 2013 cost reports in HCRIS, the Office of the Actuary assumed a discharge completion factor of 99 percent for FY 2013 and 98 percent for FY 2014. Similarly, the Office of the Actuary assumed that case-mix was stabilized at the time of the estimate and no additional completion factor adjustment was needed. These assumptions are consistent with historical patterns. Regarding the commenters' assertion that Medicaid expansion is not adequately accounted for in the ''Other'' column, we note that the Office of the Actuary assumed per capita spending for Medicaid beneficiaries who enrolled due to the expansion is 50 percent of the average per capita of the pre-expansion Medicaid beneficiary due to the better health of these beneficiaries. We have found this assumption to be consistent with recent internal estimates of Medicaid per capita spending pre-expansion and post-expansion.

In response to the commenters who requested that we adjust the ''Other'' assumption to reflect the growing number of DSH hospitals in a manner that supports safety-net hospitals, particularly in States that do not have a Medicaid or CHIP expansion, we note that our proposed methodology includes assumptions regarding how DSH payments will increase in aggregate, regardless of how many hospitals qualify for DSH payments. Furthermore, we believe that, while the statute provides the Secretary with discretion to make an estimate, the statute is clear that the computation of Factor 1 begins with an aggregate amount of payments that would be made to subsection (d) hospitals under section 1886(d)(5)(F) if this section did not apply for such fiscal year. In our view, the most appropriate way to do so is to project to the best of our abilities how payments will actually change in aggregate, based on the programs and policies that will be in effect during the fiscal year.

We agree with the commenters that CMS should use the most recent update of the 2012 Medicare cost report data available to us and note that the Office of the Actuary has done so in using the March 2015 extract of 2012 cost reports in HCRIS for this final rule.

Comment: Some commenters requested that, in light of their concerns about the data sources and methods used to estimate Factor 1, CMS adopt a process of reconciling the initial estimates of Factor 1 with actual data for the payment year in conjunction with the final settlement of hospital cost reports for the applicable year. Specifically, the commenters asserted that later data that become available after the end of a Federal fiscal year but before final DSH payment determinations are made in notices of program reimbursement would result in Factor 1 estimates that are more accurate than estimates made before the start of a Federal fiscal year. The commenters believed that a ''true-up approach'' would resolve most of what they characterize as ''discrepancies between estimates and reality.'' The commenters stated that generalized concerns about administrative ease and finality are not justifications for the use of advance estimates that are inaccurate due to ''inherent uncertainties'' in making projections of DSH payments in an ''early, post-ACA environment.'' As an example of a way by which this ''true-up'' could occur, one commenter requested the CMS update the calculation of the discharge factor used to calculate Factor 1 in an interim final rule.

Response: We continue to believe that applying our best estimates prospectively is most conducive to administrative efficiency, finality, and predictability in payments (78 FR 50628; 79 FR 50010). As we noted in the FY 2014 IPPS/LTCH PPS final rule, 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. Furthermore, the statute provides that Factor 1 shall be determined based on estimates of the aggregate amount of DSH payments that would be made in the absence of section 1886(r) of the Act and the aggregate amount of empirically justified DSH payments that are made under section 1886(r)(1) of the Act. We believe that, in affording the Secretary the discretion to estimate the amount of these payments and by including a prohibition against administrative and judicial review of those estimates in section 1886(r)(3) of the Act, Congress recognized the importance of finality and predictability in payments and sought to avoid a situation in which the uncompensated care payments would be subject to change over a period of a number of years. Accordingly, we do not agree with the commenters that we should establish a process for reconciling our estimates of Factor 1. We note that, in reviewing the Office of the Actuary's prior estimates for DSH payments compared to actual experience, from FY 2005 to FY 2016, the original estimates have been higher than actual experience for 8 of the 12 years and lower than actual experience in only 4 years.

Comment: Some commenters indicated that the estimated DSH payments do not account for the impact of the decision in *Allina* v. *Sebelius,* by excluding Medicare Advantage days from the SSI ratio and including dual eligible Medicare Advantage days in the Medicaid fraction, thus understating the estimate of Factor 1.

Response: We do not believe the *Allina* decision has any bearing on our estimate of Factor 1 for FY 2016. The holding in *Allina* addresses traditional DSH payments made to a group of providers between 2004 and 2010. Moreover, the decision did not address the FY 2014 IPPS/LTCH PPS final rule (78 FR 50614 through 50620) in which we readopted the policy of counting Medicare Advantage days in the SSI ratio for FY 2014 and all subsequent fiscal years. In its estimate of Factor 1 for FY 2016 for the FY 2016 IPPS/LTCH PPS proposed rule, the Office of the Actuary was making an estimate of difference between the aggregate amount of DSH payments that would be made under section 1886(d)(5)(F) of the Act in FY 2016 if section 1886(r) of the Act did not apply and the aggregate amount of empirically justified DSH payments that will be made to hospitals in FY 2016 under section 1886(r)(1) of the Act. Thus, although the Office of the Actuary used 2012 cost report data in making this estimate, it also applied inflation adjustments and assumptions in order to estimate Medicare DSH payments for FY 2016. Accordingly, consistent with § 412.106(b)(2), as readopted in the FY 2014 IPPS/LTCH PPS final rule, in estimating DSH payments for FY 2016, the Office of the Actuary did not remove patients enrolled in Medicare Advantage plans from SSI ratios or make any other adjustments to the hospital cost report data for 2012 included in the HCRIS database. We believe this methodology is consistent with the statute and regulations.

After consideration of the public comments we received, we are finalizing, as proposed, the methodology for calculating Factor 1 for FY 2016. Using this methodology, below we discuss the resulting Factor 1 amount for FY 2016.

To determine Factor 1 and to model the impact of this provision for FY 2016, we used the Office of the Actuary's July 2015 Medicare DSH estimates based on data from the March 2015 update of 2012 cost report data included in HCRIS, 2012 cost report data provided

to CMS by IHS hospitals, and the FY 2015 IPPS/LTCH PPS final rule IPPS Impact File, published in conjunction with the publication of the FY 2015 IPPS/LTCH PPS final rule. Because SCHs that are projected to be paid under their hospital-specific rate are not subject to the provisions of section 1886(r) of the Act, these hospitals were excluded from the July 2015 Medicare DSH estimates. Furthermore, because section 1886(r) of the Act specifies that the uncompensated care payment is in addition to the empirically justified DSH payment (or 25 percent of DSH payments that would be made without regard to section 1886(r)), Maryland hospitals participating in the Maryland All-Payer Model and hospitals participating in the Rural Community Hospital Demonstration that do not receive DSH payments also are excluded from the Office of the Actuary's Medicare DSH estimates.

Using the data sources discussed above, the Office of the Actuary applied inflation updates and assumptions for future changes in utilization and case-mix to estimate Medicare DSH payments for the upcoming fiscal year. The July 2015 Medicare DSH estimate for FY 2016, without regard to the application of section 1886(r)(1) of the Act, is $13,411,096,528.05. Based on this estimate, the estimate for empirically justified Medicare DSH payments for FY 2016, with the application of section 1886(r)(1) of the Act, is $3,352,774,132.01 (25 percent of the total amount estimated). Under § 412.106(g)(1)(i) of the regulations, Factor 1 is the difference between these two estimates of the Office of the Actuary. Therefore, for this final rule, Factor 1 for FY 2016 is $10,058,322,396.04 ($13,411,096,528.05 minus $3,352,774,132.01). Below we provide additional detail regarding the development of this estimate.

The Office of the Actuary's estimates for FY 2016 begin with a baseline of $11.637 billion in Medicare DSH expenditures for FY 2012. The following table shows the factors applied to update this baseline through the current estimate for FY 2016.

FACTORS APPLIED FOR FY 2013 THROUGH FY 2016 TO ESTIMATE MEDICARE DSH EXPENDITURES USING FY 2012 BASELINE

FY	Update	Discharge	Case-mix	Other	Total	Estimated DSH payments (in billion)
2013	1.028	0.9844	1.014	1.0137	1.040189	$12.105
2014	1.009	0.9634	1.015	0.9993	0.985961	11.935
2015	1.014	0.9893	1.005	1.0512	1.059784	12.648
2016	1.009	1.0006	1.005	1.045	1.060313	13.411

In this table, the discharge column shows the increase in the number of Medicare fee-for-service (FFS) inpatient hospital discharges. The figures for FYs 2013 and 2014 are based on Medicare claims data that have been adjusted by a completion factor. The discharge figure for FY 2015 is based on preliminary data for 2015. The discharge figure for FY 2016 is an assumption based on recent trends recovering back to the long-term trend and assumptions related to how many beneficiaries will be enrolled in Medicare FFS and also MA plans. The case-mix column shows the increase in case-mix for IPPS hospitals. The case-mix figures for FYs 2013 and 2014 are based on actual data adjusted by a completion factor. The FY 2015 and FY 2016 increases are based on the recommendation of the 2010–2011 Medicare Technical Review Panel. The ''Other'' column shows the increase in other factors that contribute to the Medicare DSH estimates. These factors include the difference between the total inpatient hospital discharges and the IPPS discharges, various adjustments to the payment rates that have been included over the years but are not reflected in the other columns (such as the increase in rates for the *Cape Cod* litigation and the reduction in rates for the 2-midnight stay policy). In addition, the ''Other'' column includes a factor for the Medicaid expansion due to the Affordable Care Act.

The table below shows the factors that are included in the ''Update'' column of the above table.

FY	Market basket percentage	Affordable care act payment reductions	Multifactor productivity adjustment	Documentation and coding percentage adjustment	Total update percentage
2013	2.6	−0.1	−0.7	+1.0	2.8
2014	2.5	−0.3	−0.5	−0.8	0.9
2015	2.9	−0.2	−0.5	−0.8	1.4
2016	2.4	−0.2	−0.5	−0.8	0.9

Note: All numbers are based on the Midsession Review of FY 2016 Budget projections.

(2) Calculation of Factor 2 for FY 2016

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 that, for each of FYs 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 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 are available (as so calculated), minus 0.1 percentage point for FY 2014 and minus 0.2 percentage point 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 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 . . .'' (emphasis added) appeared in a March 20, 2010 letter from the director of the CBO to the Speaker of the House. 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) of the Act. (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 letter to the Speaker of the House of Representatives, the CBO provided two estimates of the ''post-policy uninsured population.'' The first estimate is of the ''Insured Share of the Nonelderly Population Including All Residents'' (82 percent) and the second estimate is of the ''Insured Share of the Nonelderly Population Excluding Unauthorized Immigrants'' (83 percent). Starting in the FY 2014 IPPS/LTCH PPS final rule (78 FR 50631), we used the first estimate that includes all residents, including unauthorized immigrants. We stated that 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 of 65. In addition, we stated that we believe that this estimate more fully reflects the levels of uninsurance in the United States that influence uncompensated care for hospitals than the estimate that reflects only legal residents. 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 the applicable year with the percent of individuals who were uninsured in 2013, in the FY 2014 and FY 2015 IPPS/LTCH PPS final rules (78 FR 50631 and 79 FR 50014), we used the CBO insurance rate figure and subtracted that amount from 100 percent (that is, the total population without regard to insurance status) to estimate the 2013 baseline percent of individuals without insurance. Therefore, for FYs 2014 through 2017, per statute, our estimate of the uninsurance percentage for 2013 is 18 percent.

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 are available. In the FY 2014 and FY 2015 IPPS/LTCH PPS final rules (78 FR 50634 and 79 FR 50014), we used the same data source, the most recent available CBO estimates, to calculate this percent of individuals without insurance. In response to public comments, we also agreed that we should normalize the CBO estimates, which are based on the calendar year, for the Federal fiscal years for which each calculation of Factor 2 is made (78 FR 50633).

Consistent with the data used in FY 2014 and FY 2015, in the FY 2016 IPPS/LTCH PPS proposed rule, we used the CBO's January 2015 estimates of the effects of the Affordable Care Act on health insurance coverage (which are available at *http://www.cbo.gov/sites/default/files/cbofiles/attachments/43900-2014-04-ACAtables2.pdf*), normalized to the Federal fiscal year, to calculate the percent of individuals without insurance (80 FR 24486). The CBO's January 2015 estimate of individuals under the age of 65 with insurance in CY 2015 was 87 percent. Therefore, the CBO's most recent estimate of the rate of uninsurance in CY 2015 at the time of development of the FY 2016 IPPS/LTCH PPS proposed rule was 13 percent (that is, 100 percent minus 87 percent). Similarly, the CBO's January 2015 estimate of individuals under the age of 65 with insurance in CY 2016 was 89 percent. Therefore, the CBO's most recent estimate of the rate of uninsurance in CY 2016 available for the FY 2016 IPPS/LTCH PPS proposed rule was 11 percent (that is, 100 percent minus 89 percent).

The proposed calculation of Factor 2 for FY 2016 included in the FY 2016 IPPS/LTCH proposed rule was as follows:

- CY 2015 rate of insurance coverage (January 2015 CBO estimate): 87 percent.
- CY 2016 rate of insurance coverage (January 2015 CBO estimate): 89 percent.
- FY 2016 rate of insurance coverage: (87 percent * .25) + (89 percent * .75) = 88.5 percent.
- Percent of individuals without insurance for 2013 (March 2010 CBO estimate): 18 percent
- Percent of individuals without insurance for FY 2016 (weighted average): 11.5 percent

$1-((0.115–0.18)/0.18) = 1-0.3611 = 0.6389$ (63.89 percent) (We note that, in the proposed rule, this calculation should have read: $1 - \left|[(0.115–0.18)/0.18)\right| = 1-0.3611 = 0.6389$ (63.89 percent).)

0.6389 (63.89 percent) − .002 (0.2 percentage points for FY 2016 under section 1886(r)(2)(B)(i) of the Act) = 0.6369 or 63.69 percent

0.6369 = Factor 2

Therefore, we proposed that Factor 2 for FY 2016 would be 63.69 percent. We indicated that our proposal for Factor 2 was subject to change if more recent CBO estimates of the insurance rate became available at the time of the preparation of the final rule. We invited public comments on our proposed calculation of Factor 2 for FY 2016.

In the FY 2016 IPPS/LTCH PPS proposed rule (80 FR 24486), we stated that the FY 2016 Proposed Uncompensated Care Amount was $\$10,003,425,327.39 \times 0.6369 = \$6,371,181,591.01$.

Comment: A number of commenters objected to CMS' proposed calculation of Factor 2. The commenters questioned the accuracy of CBO's estimates and requested additional information on how the CBO calculates its insurance estimates, including the assumptions used in its estimates. For example, some commenters questioned the accuracy of the CBO's assumptions regarding ''unauthorized immigrants'' and provided information from other data sources, such as the Census Bureau, Department of Homeland Security Office of Immigration Statistics, and the Pew Research Center, to suggest that the total uninsured percentage in FY 2016 should be 13 percent rather than 11 percent as proposed. One commenter requested an explanation of why CBO changed its baseline formula for pre-Affordable Care Act coverage and how CBO is tracking actual insured and uninsured populations. Some commenters believed that the CBO insurance estimates do not take into

account States that have not expanded their Medicaid programs. Other commenters questioned whether CBO accounted for factors that ultimately affect the insured population, such as individuals who will disenroll from coverage due to their inability to pay premiums or insured individuals who are unable to pay for hospital services they receive due to high deductibles and coinsurance in employer-sponsored and exchange-sponsored plans.

Response: We note that, in the FY 2014 IPPS/LTCH PPS final rule, we finalized a policy to employ the most recent available CBO estimates of the rates of uninsurance in the calculation of Factor 2 for FY 2014 and subsequent years. As discussed in the FY 2014 IPPS/LTCH PPS final rule (78 FR 50632), 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 ''in the most recent period for which data is available (as so calculated).'' The phrase ''as so calculated'' in the latter section can be reasonably interpreted to require the calculation to similarly be based on CBO estimates. Furthermore, we continue to believe that the CBO projections of insurance coverage are the most reliable and consistent basis on which to calculate Factor 2, and that it is preferable from a statistical point of view to calculate a percent change in insurance over time using a consistent data source.

We note that CBO's coverage projections for CY 2015 and CY 2016 reflect changes in the rate of uninsurance arising from participation in the health insurance exchanges, Medicaid and CHIP enrollment, and changes in employer-sponsored, nongroup, and other insurance coverage. Unauthorized immigrants who are not eligible for Medicaid and exchange coverage and low-income residents of States not participating in the Medicaid expansion are included in the uninsured population. In addition, the estimate reflects other individuals who choose to remain uninsured, despite being eligible for Medicaid or having access through an employer, the exchange, or from an insurer. Therefore, the CBO estimates do take into account some uncertainties and risks under the Affordable Care Act, including the probabilities of different outcomes of Medicaid expansions and changes in insurance coverage status over time. More detailed explanations of the methodology and assumptions used by CBO can be accessed on the CBO Web site and particularly in the Appendix of the March 2015 Updated Budget Projections: 2015–2025 (which are available at *http://www.cbo.gov/sites/default/files/cbofiles/attachments/49973-UpdatedBudgetProjections.pdf*).

Comment: Commenters requested that CMS update the Factor 2 estimates with later data, such as through an additional interim final rule or by establishing a reconciliation process that uses actual data regarding the rate of uninsurance at the time of cost report settlements. The commenters indicated that they understood that estimates must be used for interim payments, but stated that they believed more accurate numbers based on actual experience should be available for purposes of determining final payments at the time of cost report settlement. One commenter pointed out that CBO continually revises its own projected enrollment numbers for changes in insurance coverage and thus reconciliation is appropriate because otherwise providers would ''absorb the full impact of these errors.'' Another commenter objected to the view that Factor 2 should be based solely upon estimates as opposed to actual data. The commenter pointed out that the DSH statute does not use the word ''estimate'' in connection with the computation of the second prong of Factor 2. The commenter viewed the omission of the term ''estimate'' as deliberate for the period FY 2014 through FY 2017, noting that the statute employs the term ''estimate'' elsewhere, such as in the second prong of Factor 2 for FY 2018 and beyond. This commenter asserted that the statute requires that the initial estimates of the percentage of uninsured individuals for FY 2016 and FY 2017 be reconciled with actual data when those data become available.

Many commenters believed that the information shared by CMS in the FY 2016 IPPS/LTCH PPS proposed rule would be outdated and need to be revised in light of the *King* v. *Burwell* case. The commenters noted that, as of June, no decision had been issued by the Supreme Court and that an adverse ruling for the Secretary would lead to a smaller reduction in the rate of uninsurance. Some commenters provided information regarding two studies that estimated increases in the number of uninsured individuals if the Supreme Court were to set aside the subsidies in States without State-operated exchanges. The commenters stated that, based on their understanding of these studies, there could be approximately 8.2 million to 9.8 million more individuals uninsured in CY 2016 than previously estimated, which would result in a national uninsured rate of 15.1 percent to 18.3 percent. Based on this analysis, the commenters estimated that Factor 2 should be 0.8036 or 80.36 percent, much higher than the 0.6369 or 63.69 percent proposed by CMS. The commenters stated that, all else being equal, this change to Factor 2 would result in an amount to be available for uncompensated care payments of approximately $8.0 million compared to the approximately $6.4 million proposed by CMS. The commenters stated that CMS could update this estimate in the final rule or through an interim final rule. Commenters stated that updating Factor 2 for the results of the decision in *King* v. *Burwell* would reflect CMS policy to use updated data on the rate of uninsurance. One commenter requested that CMS use updated enrollment data from the exchanges to lower its estimate of the number of insured individuals for FY 2016.

Response: In the FY 2014 IPPS/LTCH PPS final rule (78 FR 50632), we finalized a policy to employ the most recent available CBO estimates of the rate of uninsurance in the calculation of Factor 2 for FY 2014 and subsequent years, and did not adopt any policy for reconciling those estimates. In the FY 2014 IPPS/LTCH PPS final rule, we stated that we believe that employing actual data to reconcile the projections employed to determine Factor 2 would impose an unacceptable delay in the final determination of uncompensated care payments. Actual data on the rates of insurance and uninsurance do not become available until several years after the payment year, and the initial data for a year will continue to be adjusted for several years after that as further data become available. We continue to believe that determining Factor 2 prospectively by applying the best estimate of the projected level of uninsurance for the applicable fiscal year is most conducive to administrative efficiency, finality, and predictability in payments.

With respect to the commenter's concerns about language used in section 1886(r)(2)(B)(i)(II) of the Act, we acknowledge the commenter's point that the statute does not explicitly include the word ''estimate'' in describing the percent of individuals who are uninsured in the most recent period for which data are available. However, we note that the statute does describe this figure ''as so calculated.'' We continue to believe that this reference is intended to instruct the Secretary to perform the calculation in the same manner as the calculation under section 1886(r)(2)(B)(i)(I) of the Act. Section

1886(r)(2)(B)(i)(I) of the Act expressly instructs the Secretary to calculate the percent of individuals who are uninsured in 2013 ''based on the most recent *estimates* available from the Director of the Congressional Budget Office . . . .'' (Emphasis added.) Accordingly, we interpret the term ''calculated'' in section 1886(r)(2)(B)(i)(II) of the Act to mean calculated based on CBO estimates and disagree that the statute requires that we reconcile this figure with actual data.

With respect to the commenters' concerns regarding the accuracy of the Factor 2 estimate in light of the *King* v. *Burwell* case, we note that the Supreme Court's ruling in the case affirmed that individuals who purchase their health insurance on exchanges established by the Federal government are eligible for tax subsidies. As a result, we do not expect the decision to have any effect on the estimate of the percent of individuals that are uninsured in FY 2016. Moreover, we note that, because we finalized a policy in the FY 2014 IPPS/LTCH PPS final rule to use the most recent available CBO projections of insurance coverage in our calculation of Factor 2, any update to the uninsurance data used in the computation of Factor 2 must also originate from the CBO. The most recent available CBO projection of uninsurance is the March 2015 baseline available on the Web site at: *https://www.cbo.gov/sites/default/files/cbofiles/attachments/43900-2015-03-ACAtables.pdf*, and consistent with our policy, we are using this estimate in the calculation of Factor 2 for this FY 2016 IPPS/LTCH PPS final rule.

Comment: Some commenters requested that CMS work with Congress to take steps to mitigate the effect of the reduction in Factor 2 on the overall amount available to make uncompensated care payments for FY 2016. Several commenters requested that CMS delay the implementation of Factor 2 until all or substantially all of the States implement health insurance exchanges and until the level of Medicaid expansion is known on a State-by-State basis. The commenters expected that, once these events occur, more reliable information sources would be available to determine the reduction in the rate of uninsurance. Another commenter suggested that, at a minimum, CMS maintain the percentage of uninsured it applied in the FY 2015 calculation until a more accurate projection can be made. One commenter specifically mentioned using the documentation and coding adjustments as a model for phasing in reductions to the amount available for uncompensated care payments. Another commenter asked CMS to ensure the payment methodology does not harm access to care in rural areas.

Response: We thank the commenters for their alternative suggestions. We do not believe there is a statutory basis to delay the implementation of Factor 2 or to phase in reductions because the statute requires us to implement the uncompensated care payment methodology in its entirety for FY 2014 and each subsequent fiscal year. The statute also does not provide us with a basis to use the percentage of uninsured we applied for FY 2015 because the statute requires us to use the data on the percent of individuals who are uninsured in the most recent period for which data are available, and such data are available for FY 2016. Finally, although we understand the commenters' concerns regarding access to care in rural areas, the statute does not include any exception in the payment methodology for hospitals by geographic location or geographic classification. Therefore, hospitals in rural areas are subject to the same reductions as hospitals elsewhere in the country.

After consideration of the public comments we received, we are finalizing, as proposed, the calculation of Factor 2 for FY 2016. Using this methodology, below we discuss the resulting Factor 2 amount for FY 2016 and the total uncompensated care amount for FY 2016.

To determine Factor 2 for FY 2016, we used the CBO's March 2015 estimates of the effects of the Affordable Care Act on health insurance coverage (which are available at *http://www.cbo.gov/sites/default/files/cbofiles/attachments/43900-2015-03-ACAtables.pdf*). The CBO's March 2015 estimate of individuals under the age of 65 with insurance in CY 2015 is 87 percent. Therefore, the CBO's most recent estimate of the rate of uninsurance in CY 2015 is 13 percent (that is, 100 percent minus 87 percent). Similarly, the CBO's March 2015 estimate of individuals under the age of 65 with insurance in CY 2016 is 89 percent. Therefore, the CBO's most recent estimate of the rate of uninsurance in CY 2016 available for this final rule is 11 percent (that is, 100 percent minus 89 percent).

The calculation of the final Factor 2 for FY 2016, employing a weighted average of the CBO projections for CY 2015 and CY 2016, is as follows:

- CY 2015 rate of insurance coverage (March 2015 CBO estimate): 87 percent.
- CY 2016 rate of insurance coverage (March 2015 CBO estimate): 89 percent.
- FY 2016 rate of insurance coverage: (87 percent * .25) + (89 percent * .75) = 88.5 percent.
- Percent of individuals without insurance for 2013 (March 2010 CBO estimate): 18 percent.
- Percent of individuals without insurance for FY 2016 (weighted average): 11.5 percent.

$1 - \left| [(0.115 - 0.18)/0.18] \right| = 1 - 0.3611 = 0.6389$ (63.89 percent)

0.6389 (63.89 percent) − .002 (0.2 percentage points for FY 2016 under section 1886(r)(2)(B)(i) of the Act) = 0.6369 or 63.69 percent

0.6369 = Factor 2

Therefore, the final Factor 2 for FY 2016 is 63.69 percent.

The FY 2016 Final Uncompensated Care Amount is: $10,058,322,396.04 × 0.6369 = $6,406,145,534.04.

FY 2016 Final Uncompensated Care Total Available.	$6,406,145,534.04

(3) Calculation of Factor 3 for FY 2016

Section 1886(r)(2)(C) of the Act defines Factor 3 in the calculation of the uncompensated care payment. As we have discussed earlier, 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 are available that are 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 section 1886(r) of the Act 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 each subsection (d) Puerto Rico hospital with the potential to receive Medicare DSH payments relative to the estimated uncompensated care amount for all hospitals estimated to receive Medicare 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 fiscal years. In order to implement the statutory

requirements for this factor of the uncompensated care payment formula, it was necessary to determine: (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 the denominator (that is, the estimated uncompensated care amount for all hospitals estimated to receive Medicare DSH payments in the applicable fiscal year); (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 Medicare 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 such alternative data are available that are a better proxy for the costs of subsection (d) hospitals for treating individuals who are uninsured.

In the course of considering how to determine Factor 3 during the rulemaking process for FY 2014, we considered defining the amount of uncompensated care for a hospital as the uncompensated care costs of each hospital and determined that Worksheet S–10 of the Medicare cost report potentially provides the most complete data regarding uncompensated care costs for Medicare hospitals. However, because of concerns regarding variations in the data reported on the Worksheet S–10 and the completeness of these data, we did not propose to use data from the Worksheet S–10 to determine the amount of uncompensated care for FY 2014, the first year this provision was in effect, or for FY 2015. We instead employed 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 believed that these alternative data, which are currently reported on the Medicare cost report, would be a better proxy for the amount of uncompensated care provided by hospitals. We also indicated that we were expecting reporting on the Worksheet S–10 to improve over time and remained convinced that the Worksheet S–10 could ultimately serve as an appropriate source of more direct data regarding uncompensated care costs for purposes of determining Factor 3.

In the FY 2016 IPPS/LTCH PPS proposed rule (80 FR 24487), we stated that we believe it remains premature to propose the use of Worksheet S–10 for purposes of determining Factor 3 for FY 2016 and, therefore, proposed to continue to employ the utilization of insured low-income patients (defined as inpatient days of Medicaid patients plus inpatient days of Medicare SSI patients as defined in § 412.106(b)(4) and § 412.106(b)(2)(i), respectively) to determine Factor 3. We indicated that we believe that continuing to use this methodology would give hospitals more time to learn how to submit accurate and consistent data through Worksheet S–10, as well as give CMS more time to continue to work with the hospital community and others to develop the appropriate clarifications and revisions to Worksheet S–10 to ensure standardized and consistent reporting of all data elements. Accordingly, we proposed that, for FY 2016, CMS would base its estimates of the amount of hospital uncompensated care on utilization data for Medicaid and Medicare SSI patients, as determined by CMS in accordance with §§ 412.106(b)(2)(i) and (b)(4). We stated that we still intend to propose through future rulemaking the use of the Worksheet S–10 data for purposes of determining Factor 3. We invited public comments on this proposal to continue to use insured low-income days to determine Factor 3 for FY 2016.

Comment: Most commenters believed that the Worksheet S–10 data are not yet sufficiently consistent and reliable to be employed for purposes of determining each hospital's share of uncompensated care payments. Many commenters supported the proposal to continue employing Medicare SSI days and Medicaid days to determine Factor 3 for FY 2016.

Some commenters noted that the proxy is appropriate until the Worksheet S–10 data become more reliable and accurate for collecting uncompensated care costs. One commenter indicated that it had performed analyses exploring the relationship between uncompensated care costs and Medicaid expansion. Among other results, the commenter indicated that its analysis showed that the proportion of Medicaid volumes has increased while the proportion of self-pay and charity has decreased in States that have expanded their Medicaid programs. The commenter concluded that Medicaid and uncompensated care are now inversely related in States that have expanded their programs and stated that the validity of the insured low-income days proxy will soon be in question as newer data become available.

Commenters who continued to support use of the proxy for FY 2016 in order to allow for improved data collection on Worksheet S–10 focused on two areas: Changes to Worksheet S–10 and the process to audit Worksheet S–10. With regard to changes to Worksheet S–10, the commenters stated that the Worksheet S–10 form and instructions should be changed in order to improve consistency in reporting across providers and overall accuracy. They stated that the current instructions are imprecise and lack meaningful guidance from CMS. The commenters stated that often stakeholders provide specific recommendations for changes to Worksheet S–10 that CMS should consider, and encouraged CMS to work expeditiously with a broad range of stakeholders to improve Worksheet S–10. Many commenters provided detailed suggestions related to reporting requirements for specific lines of Worksheet S–10. Summaries that illustrate the breadth of the commenters' suggestions as they pertain, in general, to the reporting of uncompensated care, charity care, bad debt, and Medicaid costs are presented below.

- Commenters requested clarification of whether charity care charges should be reported for inpatient hospital services, outpatient hospital services, or both. They requested the ability to report these charges on separate lines and to apply separate CCRs to these separate sets of costs.
- Commenters noted that because Worksheet S–10 is derived from data reported on the Medicare cost report, charges and payments for physician services are currently excluded. However, the commenters stated that hospitals provide physician services to patients with little or no access to private physicians. They noted that safety-net hospitals in low-income communities particularly provide these services. The commenters believed that providers should be encouraged to provide these services and that one means to do so is to revise Worksheet S–10 to include reporting of uncompensated care related to employed physician services and to establish an uncompensated care cost methodology that takes these services into account.
- One commenter pointed out that it would be appropriate to add a self-pay category to Worksheet S–10 to distinguish this uninsured population from others who have some form of third party coverage.
- Commenters requested that the CCR used on Worksheet S–10 to convert charges to costs be changed so that it includes direct GME payments because

the charges include direct GME payments. To determine costs, that CCR is multiplied by the charges reported in column 8 charges, which include overhead charges that reflect direct GME. The commenters noted that the current source of the CCR on Worksheet S–10 is Worksheet C, and therefore the CCR does not include the cost of direct GME.

- Commenters requested that Worksheet S–10, which currently collects charity care costs based on dates of service, be changed to allow for the reporting of charity care costs based on the date the hospital writes off the charity care. The commenters stated that, under the current requirement, hospitals must spend significant additional time to document charity care write-offs. The commenters also stated that they do not believe the current approach is accurate because hospitals will not have identified and resolved all of their charity care accounts by the time they file their cost reports, which is no later than 5 months after the close of a hospital's fiscal year. The commenters stated that charity care determinations involve complexities, such as changes in specific patient circumstances and time involved in obtaining necessary documentation.
- Commenters noted that the current reporting instructions, particularly in PRM II, Section 4012, exclude discounts to patients from reporting as uncompensated care. They then noted that some States mandate such discounts, and that many hospitals provide discounts to any uninsured patient. In their view, these instructions could create a situation where hospitals are precluded from reporting these costs as charity when, in their view, this is uncompensated care.
- Some commenters believed that CMS should be clearer with regard to how charges related to indigent care programs are reported. The commenters believed that charges for services provided to this patient care population should not be considered uncompensated care costs. Other commenters disagreed and provided specific examples of the types of programs that should be included.
- Commenters requested that CMS define the use of presumptive eligibility tools as an acceptable method to identify and document charity care charges. The commenters believed that the current CMS practice of disallowing charity care based on the finding of presumptive eligibility tools is inappropriate because the current reporting instructions relate to when Medicare beneficiaries should be determined to be indigent and not the application of hospitals' charity care policies to other patient populations and these instructions were developed before presumptive eligibility tools were widely used by hospitals.
- Commenters believed that hospitals should not be required to report expected payments in addition to received payments for charity care accounts. The commenters noted that the difficulty is that the amounts expected from patients for whom there have been partial write-offs in accordance with a hospital's charity care policy are often not paid in full.
- Commenters believed that Worksheet S–10 understates charity care costs for patients who participate in high deductible plans. The commenters also believed that charity care for noncontracted insurance payers is overstated.
- One commenter suggested that bad debt be reported in three categories: Uninsured bad debt from charity patients; uninsured bad debt from noncharity patients; and cost-sharing bad debts. The commenter suggested that CCRs not be applied to bad debt charges related to cost-sharing. The commenter believed this disaggregation would yield data that are comparable to the charity care data reported on Worksheet S–10.
- Commenters requested that CMS be clear with regard to the time period for which bad debt expense should be reported. Specifically, the commenters asked that CMS clearly state that the instructions mean that a hospital should report bad debt expense as reflected on its financial statement. Furthermore, the commenters requested that CMS amend the cost reporting instructions to require hospitals to report amounts based on Generally Accepted Accounting Principles.
- Commenters advised requiring Medicaid DSH payments and Medicaid supplemental payment information to be reported on separate lines and to offset these payments against Medicaid costs reported on Worksheet S–10.
- Some commenters suggested that CMS capture data on the number of patients in various government programs so that any future formula based on Worksheet S–10 could provide differential weighting to hospitals based on their proportion of total inpatient and outpatient utilization by patients in these programs or payments from governmental payors such as Medicare and Medicaid. The commenters suggested collecting patient share information for non-dually eligible FFS Medicare beneficiaries, non-dually eligible Medicare Advantage beneficiaries, dual-eligible FFS beneficiaries, dual-eligible Medicare Advantage beneficiaries, and beneficiaries in the Fully Integrated Duals Advantage demonstration.

Many commenters requested that CMS consider an auditing process, ensure that its contractors administer such a process consistently, and make the instructions for such an audit public. The commenters did not believe that hospitals were purposefully reporting erroneous information on their costs reports. However, many of the commenters were concerned that unclear reporting instructions on the Worksheet S–10 would result in inconsistent and inaccurate reporting of data. They suggested that CMS look to the process used to audit and review the data used for the Medicare wage index annually. Specifically, the commenters requested that CMS develop timetables for the cut-off of submissions or changes to the data, that MACs be engaged to audit these data to ensure validity, consistency and accuracy across hospitals, and that CMS develop a public use file that would include Worksheet S–10 data to be used in that rulemaking cycle and the calculated uncompensated care payment distribution to each eligible hospital. The commenters also suggested that CMS institute a fatal edit in the cost report audit process for negative or zero uncompensated care costs. Relatedly, commenters requested that CMS provide hospitals a means to appeal adjustments to the Worksheet S–10.

Many commenters shared observations regarding concerns and anomalies they identified in data from Worksheet S–10. A number of commenters shared analysis, including analyses that looked at the proportion of hospitals that did not report bad debt expenses, that reported a higher amount for gross charges on Worksheet S–10 than Worksheet C, or reported CCRs that seemed inappropriately high (such as for all-inclusive rate facilities). In addition, one commenter questioned imputed values for CAHs. Other commenters noted that the current requirements result in negative uncompensated care values for some hospitals.

These commenters, as well as commenters who opposed the continuation of the proxy, also requested that CMS provide a tentative timeline and implementation process for when and how the Worksheet S–10 would be used for determining Medicare uncompensated care payments. Some commenters suggested that CMS delay the use Worksheet S–10 until an audit process is established, and suggested a delay of at least 4 years.

Some commenters requested a transition from using a Factor 3 based on insured low income days to a Factor 3 based on uncompensated care costs from another source such as Worksheet S–10. These commenters suggested a variety of methods for such a transition, including blending or combining the Factor 3 values, and also a variety of lengths for such a transition, such as 3 years or 10 years. Some commenters requested that CMS implement caps on redistribution, such as a maximum cap of 10 percent on any redistribution of uncompensated care payments for 5 years, in the absence of a transition. These commenters expressed concern regarding sudden destabilizing losses due a change in their uncompensated care payments, noting that providing for a transition would prevent financial shocks to hospitals and create an incentive for them to more accurately report uncompensated care on Worksheet S–10.

Some commenters suggested how CMS should define uncompensated care using information from Worksheet S–10 and additional information that they believed should be collected in order to determine uncompensated care. For example, the commenters believed that bad debts and charity care should be included in the definition of uncompensated care. Some commenters specifically indicated that they believe that CMS should treat the uncompensated portion of state or local indigent care programs as charity care. The commenters also believed that costs not covered by Medicaid payments should be included in the definition of uncompensated care because they are not compensated. The commenters also noted that this approach would improve consistency across hospitals for comparison purposes because some hospitals treat some of these costs as charity care costs based on their charity care policies. Commenters provided different views with regard to publicly funded indigent care programs. Some commenters believed that charges for services provided to these patient populations should not be included. Other commenters believed that these charges should be included and that neither private nor public grant monies should be subtracted from them.

Response: We appreciate the commenters' support for the use of data on low-income insured days as a proxy for uncompensated care in calculating uncompensated care payments until Worksheet S–10 data become more reliable. We expect reporting on Worksheet S–10 to improve over time, both in accuracy and consistency, particularly in the area of charity care, which is already being used and audited for payment determinations related to the EHR Incentive Program. Since the publication of the FY 2014 IPPS/LTCH PPS final rule, we have continued to evaluate and assess the comments we have received from stakeholders about Worksheet S–10 as well as to consider what changes might need to be made to the instructions to improve the data submitted by hospitals. Although we have not decided upon revisions to the Worksheet S–10 instructions at this time, we remain committed to making improvements to Worksheet S–10 if we find they are warranted. We appreciate the specific recommendations from commenters for changing the Worksheet S–10 form and instructions and will take them into consideration as we continue to evaluate reporting on Worksheet S–10.

We have noted that we expect to proceed with a proposal to use data on the Worksheet S–10 to determine uncompensated care costs in the future and also have indicated that we will take steps such as revising and clarifying cost report instructions, as appropriate. We have stated that it is our intention to propose introducing the use of the Worksheet S–10 data for purposes of determining Factor 3 within a reasonable amount of time. At this time, we are considering a possible timeline for using Worksheet S–10 data to calculate Factor 3, and we intend to discuss this further in the FY 2017 IPPS proposed rule, which is typically released in April of the preceding fiscal year.

Comment: Several commenters objected to the proposal to calculate Factor 3 based on a hospital's share of total Medicaid days and Medicare SSI days as a proxy for measuring a hospital's share of uncompensated care. Many of these commenters believed that continued use of the proxy rewards providers in States where Medicaid has expanded. The commenters asserted that CMS should not finalize its proposal to use low-income insured days as a proxy for uncompensated care costs as proposed and instead supported the use of Worksheet S–10 data to determine uncompensated care costs for FY 2016. In particular, MedPAC disagreed with CMS' statement that the data on utilization for insured low-income patients can serve as a reasonable proxy for the treatment costs of uninsured patients. MedPAC specifically cited its 2007 analysis of data from the GAO and data from the American Hospital Association (AHA), which suggests that Medicaid days and low-income Medicare days are not a good proxy for uncompensated care costs. MedPAC also provided additional analyses that found that current Worksheet S–10 data, compared to Medicaid/Medicare SSI days, are a better proxy for predicting audited uncompensated care costs. Specifically, MedPAC included an analysis testing whether data from the Worksheet S–10 or Medicaid and Medicare SSI days are a better indicator of costs associated with caring for the uninsured. The analysis compared 2011 data from Worksheet S–10 and 2011 Medicaid and Medicare SSI days with 2009 audited data obtained from the Medicaid and CHIP Payment and Access Commission (MACPAC). The analysis found that the correlation between audited uncompensated care data and data from the Worksheet S–10 was over 0.80, whereas the correlation between audited uncompensated care data and Medicaid and Medicare SSI days was only about 0.50. Moreover, the analysis found that the 2011 S–10 data explained over 60 percent of the variance in audited uncompensated care costs whereas Medicaid days and Medicare SSI days only explain about 25 percent of the variance. Therefore, MedPAC believed that using Medicare SSI/Medicaid days as a proxy for uncompensated care does not appropriately target hospitals with the highest burden of uncompensated care costs and supported Worksheet S–10 in the Medicare cost report as an appropriate measure of uncompensated care that could begin to replace the reliance on Medicaid and Medicare SSI day shares. In response to concerns about whether the quality of the data reported on Worksheet S–10 is adequate for use in distributing uncompensated care payments, MedPAC argued that these data are already better than using Medicaid and Medicare SSI days as a proxy for uncompensated care costs, and that the data on Worksheet S–10 will improve over time as the data are actually used in making payments.

Response: As we stated in the FY 2014 and FY 2015 IPPS/LTCH PPS final rules, 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 that continue to be expressed by commenters regarding the accuracy and consistency of the data reported on the Worksheet S–10, we continue to believe that Medicaid and Medicare SSI days remain a better proxy at this time for the amount of uncompensated care provided by hospitals. However, we remain convinced that Worksheet S–10 can ultimately serve as an appropriate source of more direct data regarding

uncompensated care costs for purposes of determining Factor 3. 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 it is not unreasonable to expect information on the cost report to be used for payment purposes. We are continuing to review available data on the suitability of the Worksheet S–10 data, and are encouraged by MedPAC's analysis showing a high correlation between Medicaid audited uncompensated care data and data reported on Worksheet S–10. We also are refining our benchmarking analyses in order to compare available Worksheet S–10 data to other data sources on uncompensated care, such as uncompensated care costs reported to the Internal Revenue Service on Form 990 by not-for-profit hospitals.

As discussed in the FY 2014 IPPS/LTCH PPS final rule (78 FR 50639), in using Medicaid and Medicare SSI days as a proxy for uncompensated care, we recognize it would be possible for hospitals in States that choose to expand Medicaid to receive higher uncompensated care payments because they may have more Medicaid patient days than hospitals in a State that does not choose to expand Medicaid. Regardless, for the reasons discussed above, we believe that data on insured low-income days remain the best proxy for uncompensated care costs currently available to determine Factor 3.

Comment: One commenter believed that the current methodology utilizing low-income insured days as a proxy for uncompensated care does not differentiate between the types of inpatient days or consider the degree of acuity for patients with advanced medical conditions. The commenter suggested that CMS apply a wage and case-mix adjustment to the Medicaid and Medicare SSI days using the hospital area wage index and hospital-specific case-mix index. The commenter believed that this adjustment was appropriate in order to measure cost variation among hospitals.

Response: We appreciate the commenter's expression of the need to wage and case-mix adjust the Medicaid and SSI days, but we continue to believe it is not appropriate to apply a wage index or case-mix adjustment to low-income days to calculate Factor 3 for FY 2016. Although wage index information is readily available, for the reasons discussed in the FY 2014 IPPS/LTCH PPS final rule (78 FR 50639) and the FY 2015 IPPS/LTCH PPS final rule (79 FR 50017), we continue to believe that it is not an accurate measure of the intensity of uncompensated care costs and would not serve as an appropriate basis for making adjustments to Factor 3. As for case-mix information, as stated in the FY 2014 IPPS/LTCH PPS final rule (78 FR 50636), these data continue to be unavailable to us.

Comment: One commenter requested that CMS consider the possibility of using a proxy for SSI days in the calculation of Factor 3 and for other purposes related to DSH for Puerto Rico. The commenter noted that U.S. citizens residing in Puerto Rico are not entitled to SSI benefits, and that the reliance upon SSI enrollment in calculating Factor 3 results in uncompensated care payments that are unintentionally and unfairly lower for providers in Puerto Rico.

Response: As discussed earlier, we are currently using the utilization of insured low-income patients, defined as inpatient days of Medicaid patients plus inpatient days of Medicare SSI patients, as a proxy to estimate a hospital's uncompensated care. When we adopted this methodology for distributing uncompensated care payments for FY 2014, we estimated Puerto Rico hospitals would receive a 41.3 percent increase in Medicare DSH and uncompensated care payments (78 FR 51009). While this increase was moderated with a reduction of 7.7 percent in FY 2015 (79 FR 50412), the methodology used to determine uncompensated care payments significantly benefitted Puerto Rico hospitals relative to the methodology used to determine DSH payments under section 1886(d)(5)(F) of the Act. Further, as previously discussed, it is our intention to propose introducing the use of Worksheet S–10 of the Medicare cost report for purposes of distributing the uncompensated care payments within a reasonable amount of time. We note that eligibility for SSI days will not be an issue in determining uncompensated care payments after the move to Worksheet S–10 because Medicare SSI days will no longer be used in the distribution methodology. We have encouraged Puerto Rico hospitals to report uncompensated care costs on Worksheet S–10 of the Medicare cost report completely and accurately so that when we transition to the use of the Worksheet S–10, they can continue to receive the share of the uncompensated care payments to which they are entitled. If Puerto Rico hospitals do not properly report uncompensated care costs on Worksheet S–10, they risk a substantial reduction in future payments.

In the interim, until we are ready move to use of Worksheet S–10 for distributing the uncompensated care payments, we acknowledge that use of SSI Medicare inpatient days in the distribution of uncompensated care payments may disadvantage Puerto Rico hospitals. However, as there was no proposal to modify the methodology for distributing uncompensated care payments to Puerto Rico hospitals in the FY 2016 IPPS/LTCH PPS proposed rule, we do not believe that there would be logical outgrowth to adopt such a change in this FY 2016 IPPS/LTCH PPS final rule. Any change to the proxy used to determine uncompensated care for Puerto Rico hospitals would need to be adopted through notice-and-comment rulemaking. We plan to address this issue for inclusion in the FY 2017 IPPS/LTCH PPS proposed rule if we also propose to continue using inpatient days of Medicare SSI patients as a proxy for uncompensated care in FY 2017.

Comment: Some commenters asserted that the FY 2016 IPPS/LTCH PPS proposed rule failed to address the impact of *Allina* v. *Sebelius* on the Medicare DSH and uncompensated care formulas. The commenters asserted that, with regard to Medicaid and Medicare SSI days used in the calculation of Factor 3, the FY 2011/2012 cost reports do not appropriately reflect dual eligible MA days in conjunction with the court's ruling in *Allina.* In addition, one commenter stated that the 2013 SSI ratios, which were released by CMS in May 2015, appear to include MA days, which is inconsistent with the court's ruling in the *Allina* case.

Response: We do not believe the *Allina* decision has any bearing on our estimate of Factor 3 for FY 2016. The decision in *Allina* did not address the issue of how patient days should be counted for purposes of estimating uncompensated care. Moreover, section 1886(r)(2)(C) of the Act provides discretion for the Secretary to determine how to estimate uncompensated care costs. We continue to believe that, for purposes of determining uncompensated care payments, Medicare SSI days should include both MA and FFS SSI days.

After consideration of the public comments we received, we continue to believe that using low-income insured days as a proxy for uncompensated care costs provides a reasonable basis to determine Factor 3 as we work to improve Worksheet S–10 to accurately and consistently capture uncompensated care costs. Accordingly, in this final rule, we are finalizing for FY 2016 the policy that we originally adopted in the FY 2014 IPPS/LTCH PPS

final rule, of employing 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 for FY 2016. Details on the calculation of Factor 3 for FY 2016 follow.

As we did for the FY 2014 and FY 2015 IPPS/LTCH PPS proposed rules, for the FY 2016 IPPS/LTCH PPS proposed rule, we published on the CMS Web site a table listing Factor 3 for all hospitals that we estimated would receive empirically justified Medicare DSH payments in FY 2016 (that is, hospitals that we projected would receive interim uncompensated care payments during the fiscal year), and for the remaining subsection (d) hospitals and subsection (d) Puerto Rico hospitals that have the potential of receiving a DSH payment in the event that they receive an empirically justified Medicare DSH payment for the fiscal year as determined at cost report settlement. Hospitals had 60 days from the date of public display of the FY 2016 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 closed or converted to a CAH.

After the publication of this FY 2016 IPPS/LTCH final rule, hospitals will have until August 31, 2015, to review and submit comments on the accuracy of these tables. Comments can be submitted to the CMS inbox at *Section3133DSH@cms.hhs.gov* through August 31, 2015, and any changes to Factor 3 will be posted on the CMS Web site prior to October 1, 2015.

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, section 1886(r)(2)(C)(i) of the Act defines the numerator of the quotient as the amount of uncompensated care for such hospital *for a period selected by the Secretary*. Section 1886(r)(2)(C)(ii) of the Act defines the denominator as the aggregate amount of uncompensated care for all subsection (d) hospitals that receive a payment under section 1886(r) of the Act *for such period*. In the FY 2014 IPPS/LTCH PPS final rule (78 FR 50638), we adopted 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 process, we also determined the time period from which to calculate the numerator and denominator of the Factor 3 quotient in a way that would 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 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.

In the FY 2015 IPPS/LTCH PPS final rule (79 FR 50018), we finalized a policy to use the most recently available full year of Medicare cost report data for determining Medicaid days and the most recently available SSI ratios. This is consistent with the policy we adopted in the FY 2014 IPPS/LTCH PPS final rule (78 FR 50638) of calculating 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 used data from the most recently available full year cost report for the Medicaid days, the most recent cost report data submitted to CMS by IHS hospitals, 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. Therefore, to estimate Factor 3 for FY 2015, we used data from the most recently available full year cost report and the most recent cost report data submitted to CMS by IHS hospitals for the Medicaid days and the most recently available SSI ratios, which for FY 2015 were data obtained from the 2011/2012 cost reports and the 2010 cost report data submitted by IHS hospitals for the Medicaid days, and the FY 2012 SSI ratios for the Medicare SSI days.

Since the publication of the FY 2015 IPPS/LTCH PPS final rule, we have been informed by the hospital community that they are experiencing difficulties with submitting accurate data for Medicaid days within the timeframes noted in the Provider Reimbursement Manual, Part 2, for a variety of reasons, such as their ability to receive eligibility data from State Medicaid agencies. (As outlined in Section 104, Chapter 1, of the Provider Reimbursement Manual, Part 2, a hospital generally has 5 months after the close of its cost reporting period to file its cost report.) In addition, we have been informed that there is variation in the ability of hospitals and MACs, respectively, to submit and accept amended cost report data in time for the computation of Factor 3. While we continue to believe that it is important to use data that are as recent as possible, we recognize that, from time to time, the balance between recency and accuracy may require refinement. In the case of Factor 3, because we make prospective determinations of the uncompensated care payment without reconciliation, we believe that it would increase the accuracy of the data used to determine Factor 3, and accordingly, each eligible hospital's allocation of the overall uncompensated care amount, if we provided hospitals with more time to submit these data and MACs with more time to consider these submitted data before they are used in the computation of Factor 3. As we described in the FY 2015 IPPS/LTCH PPS final rule (79 FR 50018), it is not possible for us to wait for a later database update of the cost report data to calculate the final Factor 3 amount for the final rule because this could cause delay in the publication of the final rule. Therefore, we are unable to provide hospitals additional time to submit supplemental data, or for their MACs to consider and accept those data as applicable and appropriate. In the FY 2016 IPPS/LTCH PPS proposed rule (80 FR 24488), we noted that one alternative would be to use slightly older data within the most recent extract of the hospital cost report data in the HCRIS database. We stated that we believe this would allow hospitals more time to submit data and MACs more time to consider and accept such data as applicable and appropriate.

Therefore, in the FY 2016 IPPS/LTCH PPS proposed rule (80 FR 24488), for the computation of Factor 3 for FY 2016, we proposed to hold constant the cost report years used to calculate Factor 3 and to use data from the 12-month 2012 or 2011 cost reports and, in the case of IHS hospitals, the 2012 cost report data submitted to CMS by IHS hospitals. However, because a more recent HCRIS database was available at the time of the development of the FY 2016 proposed rule, we proposed that we would continue to use the most recent HCRIS database extract available to us at the time of the annual rulemaking cycle. We noted that, as in prior years, if the more recent of the two cost reporting periods does not reflect data for a 12-month period, we would use data from the earlier of the two periods so long as that earlier period reflects data for a period of 12 months. If neither of the two periods reflects 12 months, we would use the period that reflects a longer amount of time. We proposed to codify this change for FY 2016 by amending

the regulations at § 412.106(g)(1)(iii)(C). We invited public comments on this proposal, which we describe more fully below.

For the FY 2015 IPPS/LTCH PPS final rule, we used the more recent of the full year 2012 or full year 2011 data from the March 2014 update of the hospital cost report data in the HCRIS database and 2010 cost report data submitted to CMS by IHS hospitals as of March 2014 to obtain the Medicaid days to calculate Factor 3. In addition, we used the FY 2012 SSI ratios published on the following CMS Web site to calculate Factor 3: *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Dsh.html*. In contrast, under our proposal for FY 2016, we indicated we would use the more recent of the full year 2012 or full year 2011 data from the March 2015 update of the hospital cost report data in the HCRIS database and the 2012 cost report data submitted to CMS by IHS hospitals to obtain the Medicaid days to calculate Factor 3. In addition, to calculate Factor 3 for FY 2016, we anticipated that, under our proposal, we would use the FY 2013 SSI ratios that we expected to be published on the CMS Web site but were not yet available before the public display of the proposed rule. For illustration purposes, in Table 18 associated with the FY 2016 proposed rule (which is available via the Internet on the CMS Web site at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2016-IPPS-Proposed-Rule-Home-Page-Items/FY2016-IPPS-Proposed-Rule-Tables.html*), we computed Factor 3 using the more recent of the full year 2012 or 2011 data from the December 2014 update of the hospital cost report data in the HCRIS database to obtain the Medicaid days and the FY 2012 SSI ratios published on the CMS Web site. We anticipated using the more recent of the full year 2012 or 2011 data from the March 2015 update of the hospital cost report data in the HCRIS database to obtain the Medicaid days and the FY 2013 SSI ratios to determine the final Factor 3 for FY 2016.

In the FY 2016 IPPS/LTCH PPS proposed rule (80 FR 24488), we stated that for subsequent years, if we propose and finalize a policy of using insured low-income days in computing Factor 3, we intend to continue to use the most recent HCRIS database extract at the time of the annual rulemaking cycle, and to use the subsequent year of cost reports, as applicable, using the methodology described above (that is, to advance the 12-month cost reports by 1 year). We noted that, starting with the 2013 cost reports, data for IHS hospitals will be included in the HCRIS. Therefore, if an IHS hospital has a 12-month 2013 cost reporting period in the HCRIS database, we will not need to use the 2012 data separately submitted to CMS by the IHS hospital. For example, if we finalize for FY 2017, a policy under which Factor 3 is determined on the basis of insured low-income days, this approach would result in the use of the more recent of the 12-month 2013 or 2012 cost reports in the most recent HCRIS database extract available at the time of rulemaking. In addition, for any subsequent years in which we finalize a policy to use insured low-income days to compute Factor 3, our intention would be to continue to use the most recently available SSI ratio data to calculate Factor 3 at the time of annual rulemaking. As we indicated in the FY 2016 IPPS/LTCH PPS proposed rule, we believe that it is appropriate to state our intentions regarding the specific data we would use in the event Factor 3 is determined on the basis of low-income insured days for subsequent years to provide hospitals with as much guidance as possible so they may best consider how and when to submit cost report information in the future. We note that we will make proposals with regard to our methodology for calculating Factor 3 for subsequent years through notice-and-comment rulemaking.

Comment: Several commenters supported the proposal to use more recent of the full year 2012 or 2011 data from the March 2015 update of the hospital cost report data in the HCRIS database to obtain the Medicaid days and the FY 2013 SSI ratios to determine the final Factor 3 for FY 2016. Other commenters stated that they did not oppose the proposal.

Response: We appreciate the commenters' support for or lack of opposition to this proposal.

Comment: Several commenters questioned the data used to calculate the hospitals' Factor 3 and requested clarifications on various aspects of the proposed policy. For example, several commenters stated that their Medicaid days were understated, and other commenters stated that their Medicaid days were based on a 6-month cost report and they should be based on a 12-month cost report either by combining cost reports or annualizing the data. Several commenters requested that CMS clarify whether the 12-month 2012 cost report would have to fall within the Federal fiscal year, or if CMS intends to use the full year cost report from previous years if there are no full year cost reports during the period. One commenter suggested that, for a new hospital for which the applicable historical cost reporting data represent less than 12 months, CMS use the full 12-month cost reporting data that are closest to the cost reporting period selected for determining Factor 3 in the FY 2016 IPPS/LTCH PPS final rule even if these cost reporting data are more recent than the selected period. The commenter also recommended, as an alternative, that CMS allow a new hospital to settle its uncompensated care payment on its filed cost report for the applicable fiscal year until the cost reporting period data that are applicable for computing Factor 3 include a full 12-month cost reporting period. One commenter asked for clarification on which SSI ratios will be used to settle the FY 2015 and FY 2016 cost reports, as well as which SSI ratios will be used for what purpose. A number of commenters provided information regarding their Medicaid days and requested changes based on that information.

Response: We appreciate the commenters raising these data concerns and areas of needed clarification. We are finalizing our proposal to calculate Factor 3 using SSI days from the FY 2013 SSI ratios and Medicaid days from 2012 cost report data submitted to CMS by IHS hospitals and the more recent of hospital-specific full year 2012 cost reports (unless that cost report is unavailable or reflects less than a full 12-month year, in which case we will use the cost report from 2012 or 2011 that is closest to being a full 12-month cost report) from the March 2015 update of the hospital cost report data in the HCRIS database. We also are finalizing our proposed revisions to the regulation at § 412.106(g)(1)(iii)(C), which codifies the cost reporting periods selected for purposes of determining Factor 3 of the uncompensated care payment methodology for FY 2016. We note that since we issued the FY 2016 IPPS/LTCH PPS proposed rule, the FY 2013 SSI ratios have become available on the CMS Web site at: *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Dsh.html*. We also clarify that the 12-month cost report does not need to coincide with the Federal fiscal year.

With regard to the comments from hospitals that found their Factor 3 was calculated using a cost report that was less than 12 months, we are finalizing our proposal to use the 2012 cost report, unless that cost report is unavailable or reflects less than a full 12-month year. In the event the 2012 cost report is for less than 12 months, we will use the cost report from 2012 or 2011 that is

closest to being a full 12-month cost report. In the case where a less than 12-month cost report is used to calculate a hospital's Factor 3, this would indicate that both the 2012 and 2011 cost reports were less than 12 months. In such a case, we will use the longer of the two cost reports to calculate a hospital's Factor 3. We note that section 1886(r)(2)(C) of the Act specifies that Factor 3 is equal to the percent that represents the amount of uncompensated care for such hospital for a period selected by the Secretary (as estimated by the Secretary, based on appropriate data divided by the aggregate amount of uncompensated care for all subsection (d) hospitals that receive a payment for such period (as so estimated). In implementing this provision, as we did through rulemaking in the FY 2014 IPPS/LTCH PPS final rule, we noted that we believed it was appropriate to first select the period—in that case, the period for which we had the most recently available data—and then to select the data from a cost report that aligns best with that period. Based upon our experience with implementing the provision for FY 2014 and FY 2015, we have determined that it is more appropriate to use the most recent extract of hospital cost report data for a slightly earlier period in order to give hospitals more time to submit data and MACs more time to consider and accept that data. As we have discussed, we believe this policy will improve the accuracy of the data used to calculate Factor 3. However, we acknowledge that the situations presented by commenters, where a hospital remains in operation in both Federal fiscal years for which we analyze cost report data but submits cost reports for both Federal fiscal years that reflect substantially less than a full year of data, pose unique challenges in the context of estimating Factor 3. We did not make a proposal to annualize or combine cost reports to calculate Factor 3. As a result, this is an issue that we intend to consider further and may address in future rulemaking.

As stated in the FY 2014 IPPS/LTCH PPS final rule (78 FR 50643), for new hospitals, which for Medicare DSH purposes include hospitals with a CCN established after 2012, we do not have data currently available to determine if the new hospital is eligible for empirically justified Medicare DSH payments and, therefore, eligible to receive an uncompensated care payment for FY 2016, nor do we have the data necessary to calculate a Factor 3 amount. Accordingly, we will treat new hospitals in the same manner as hospitals that are not found to be eligible to receive empirically justified Medicare DSH payments based upon the most recent available cost report from 2012 or 2011, such that the hospital may not receive either interim empirically justified Medicare DSH payments or interim uncompensated care payments. However, if the hospital is later determined to be eligible to receive empirically justified Medicare DSH payments based on its FY 2016 cost report, the hospital also will receive an uncompensated care payment based on the sum of Medicaid days and Medicare SSI days reported on its FY 2016 cost report.

In response to the commenters' concerns about which SSI ratios will be used for what purpose, we note that, consistent with our methodology in FY 2014 and FY 2015, the most recently available SSI ratios, in conjunction with the Medicaid fraction listed in the most recent update of the Provider Specific File, are used to identify which hospitals are projected to receive empirically justified DSH payments for FY 2016, and thus are eligible to receive interim uncompensated care payments for FY 2016. For this FY 2016 IPPS/LTCH PPS final rule, the 2013 SSI ratios are the most recently available SSI ratios and the March 2015 update is the most recent update of the Provider Specific File. The final determination as to whether a hospital is eligible to receive empirically justified DSH payments and therefore eligible to receive an uncompensated care payment is made at cost report settlement using the SSI ratio and Medicaid fraction reported on the provider's FY 2016 cost report. Therefore, for FY 2016, the 2013 SSI ratios are used to project eligibility to receive interim empirically justified DSH payments and interim uncompensated care payments, and the 2016 SSI ratios are used to determine, at cost report settlement, whether the hospital is ultimately eligible for empirically justified DSH payments and the uncompensated care payment. Furthermore, as stated elsewhere in this final rule, the SSI days from the 2013 SSI ratios are used in computing Factor 3. The calculation of Factor 3 in this final rule is a final determination that is not subject to review and will not be revised at cost report settlement to reflect updated information regarding the eligibility of individual hospitals for empirically justified DSH payments and uncompensated care payments.

Comment: Several commenters requested additional time after the publication of the final rule to review the data used to calculate Factor 3 and submit corrections. Some commenters asked questions regarding whether or not Medicaid days from more recent cost reports than the cost reporting periods we proposed to use could be included for their hospitals in determining Factor 3 for FY 2016. Some of these commenters included specific information and copies of documentation related to these days.

Response: We thank the commenters for their submissions. Regarding the data used to calculate Factor 3, we believe that the SSI days from the FY 2013 SSI ratios and Medicaid days from the more recent of hospitals' 2012 or 2011 cost report (that encompasses a period closest to 12 months) from the March 2015 HCRIS extract, as well as Medicaid days from 2012 cost report data submitted to CMS by IHS hospitals, should be used to determine Factor 3. As we stated above, we believe using 2011/2012 cost report data will allow hospitals more time to submit their cost report data and MACs more time to consider and accept such data as applicable and appropriate, thus balancing recency and accuracy. We cannot allow for further updates and revisions to the data used to determine Factor 3 because they would cause an unacceptable delay in the publication of this final rule and prevent changes and updates to payments under the IPPS from taking effect on October 1, the first day of the fiscal year. Furthermore, the statute provides the Secretary with the authority and discretion to estimate the amount of uncompensated care for a hospital and also provides the Secretary with the authority and discretion to select the time period for which this uncompensated care amount is estimated.

In the FY 2016 IPPS/LTCH PPS proposed rule (80 FR 24488), we proposed to continue the policies that were finalized in the FY 2015 IPPS/LTCH PPS final rule (79 FR 50020) to address several specific issues concerning the process and data to be employed in determining Factor 3 in the case of hospital mergers for FY 2016 and subsequent fiscal years. In order to confirm mergers and ensure the accuracy of the data used to determine each merged hospital's uncompensated care payment, we stated that we would publish a table on the CMS Web site, in conjunction with the issuance of each Federal fiscal year's IPPS/LTCH PPS proposed and final rules, that contains a list of the mergers that we are aware of and the computed uncompensated care payment for each merged hospital. Hospitals have 60 days from the date of public display of each year's IPPS/LTCH PPS proposed rule to review these tables and notify CMS in writing of any

inaccuracies. After the publication of the IPPS/LTCH PPS final rule, hospitals will have until August 31 of that year (for FY 2016, the deadline is August 31, 2015) to review and submit comments on the accuracy of the table for the applicable fiscal year. Comments can be submitted to our inbox at *Section3133DSH@cms.hhs.gov* through August 31, and any changes to Factor 3 will be posted on the CMS Web site prior to the start of the applicable fiscal year on October 1. We invited public comments on our proposal to continue these policies concerning the process and data to be employed in determining Factor 3 in the case of hospital mergers, as described above.

Comment: Some commenters provided detailed information regarding specific merger situations involving their hospitals and requested that CMS consider these mergers in determining Factor 3 for FY 2016. One commenter expressed concern that if a hospital is not identified as having undergone a merger prior to the public display of the final rule, a recalculation would be performed on the surviving hospital's Factor 3 at the end of the applicable fiscal year in which the merger has taken place. The commenter was concerned that this process may result in an extended delay before a hospital's uncompensated care payment is corrected and may result in understated interim uncompensated care payments. The commenter recommended an alternate approach for the recalculation of a hospital's Factor 3 that utilizes the tentative settlement process currently used by the MACs for the purpose of updating the hospital's payment rate prior to final settlement.

Response: We appreciate the commenters' input. As in FY 2015, we published a table on the CMS Web site in conjunction with the issuance of the proposed rule containing a list of the mergers that we are aware of and the computed uncompensated care payment for each merged hospital. The affected hospitals had the opportunity to comment during the public comment period on the accuracy of this information. We have updated our list of mergers based on information submitted by the MACs as of June 2015. In addition, we have reviewed the commenters' submissions of mergers not previously identified in the proposed rule and have updated our list accordingly.

While we continue to believe that recalculation of a surviving hospital's Factor 3 at cost report settlement is the most conducive to administrative efficiency and predictability for both providers and MACs, we may explore the possibility of an alternative approach in which recalculation occurs during the tentative settlement process in future notice-and-comment rulemaking. In addition, we remind the commenters that, in the event that a merger is not identified by the MACs, we allow opportunity for comment on the accuracy of the mergers that we have identified during the comment period for the proposed rule and after the publication of the final rule. Hospitals have until August 31, 2015 to review and submit comments on the accuracy of the list of mergers that we have identified in this final rule.

E. Hospital Readmissions Reduction Program: Changes for FY 2016 Through FY 2017 (§§ 412.150 through 412.154)

1. Statutory Basis for the Hospital Readmissions Reduction Program

Section 3025 of the Affordable Care Act, as amended by section 10309 of the Affordable Care Act, added a new section 1886(q) to the Act. Section 1886(q) of the Act establishes the ''Hospital Readmissions Reduction Program,'' effective for discharges from an ''applicable hospital'' beginning on or after October 1, 2012, under which payments to those applicable hospitals may be reduced to account for certain excess readmissions.

Section 1886(q)(1) of the Act sets forth the methodology by which payments to ''applicable hospitals'' will be adjusted to account for excess readmissions. In accordance with section 1886(q)(1) of the Act, payments for discharges from an ''applicable hospital'' will be an amount equal to the product of the ''base operating DRG payment amount'' and the adjustment factor for the hospital for the fiscal year. That is, ''base operating DRG payments'' are reduced by a hospital-specific adjustment factor that accounts for the hospital's excess readmissions. Section 1886(q)(2) of the Act defines the base operating DRG payment amount as the payment amount that would otherwise be made under section 1886(d) of the Act (determined without regard to section 1886(o) of the Act [the Hospital VBP Program]) for a discharge if this subsection did not apply; reduced by any portion of such payment amount that is attributable to payments under paragraphs (5)(A), (5)(B), (5)(F), and (12) of section 1886(d) of the Act. Paragraphs (5)(A), (5)(B), (5)(F), and (12) of section 1886(d) of the Act refer to outlier payments, IME payments, DSH adjustment payments, and add-on payments for low-volume hospitals, respectively.

Furthermore, section 1886(q)(2)(B) of the Act specifies special rules for defining the payment amount that would otherwise be made under section 1886(d) of the Act for certain hospitals, including policies for SCHs and for MDHs for FY 2013. In the FY 2013 IPPS/LTCH PPS final rule (77 FR 53374), we finalized policies to implement the statutory provisions related to the definition of ''base operating DRG payment amount'' with respect to those hospitals.

Section 1886(q)(3)(A) of the Act defines the ''adjustment factor'' for an applicable hospital for a fiscal year as equal to the greater of (i) the ratio described in subparagraph (B) for the hospital for the applicable period (as defined in paragraph (5)(D)) for such fiscal year; or (ii) the floor adjustment factor specified in subparagraph (C). Section 1886(q)(3)(B) of the Act, in turn, describes the ratio used to calculate the adjustment factor. It states that the ratio is equal to 1 minus the ratio of—(i) the aggregate payments for excess readmissions and (ii) the aggregate payments for all discharges. Section 1886(q)(3)(C) of the Act establishes the floor adjustment factor, which is set at 0.97 for FY 2015 and subsequent fiscal years.

Section 1886(q)(4) of the Act defines the terms ''aggregate payments for excess readmissions'' and ''aggregate payments for all discharges'' for an applicable hospital for the applicable period. The term ''aggregate payments for excess readmissions'' is defined in section 1886(q)(4)(A) of the Act as the sum, for applicable conditions of the product, for each applicable condition, of (i) The base operating DRG payment amount for such hospital for such applicable period for such condition; (ii) the number of admissions for such condition for such hospital for such applicable period; and (iii) the excess readmissions ratio for such hospital for such applicable period minus 1. The ''excess readmissions ratio'' is a hospital-specific ratio based on each applicable condition. Specifically, section 1886(q)(4)(C) of the Act defines the excess readmissions ratio as the ratio of actual-over-expected readmissions; specifically, the ratio of ''risk-adjusted readmissions based on actual readmissions'' for an applicable hospital for each applicable condition, to the ''risk-adjusted expected readmissions'' for the applicable hospital for the applicable condition.

Section 1886(q)(5) of the Act provides definitions of ''applicable condition,'' ''expansion of applicable conditions,'' ''applicable hospital,'' ''applicable period,'' and ''readmission.'' The term