earlier in this section.) We note that a hospital must continue to meet the applicable qualifying criteria as a low-volume hospital (that is, the hospital must meet the applicable discharge criterion and mileage criterion for the fiscal year) in order to receive the payment adjustment in that fiscal year; that is, low-volume hospital status is not based on a "one-time" qualification (75 FR 50238 through 50275). Consistent with historical policy, a hospital must submit its request, including this written verification, for each fiscal year for which it seeks to receive the low-volume hospital payment adjustment, and in accordance with the timeline described earlier.

F. Indirect Medical Education (IME) Payment Adjustment Factor (§ 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 2021, the formula multiplier is 1.35. We estimate that application of this formula multiplier for the FY 2021 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.

G. Payment Adjustment for Medicare Disproportionate Share Hospitals (DSHs) for FY 2021 (§ 412.106)

1. General Discussion

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 statutory references to "days" in section 1886(d)(5)(F) of the Act have been interpreted to apply only to hospital acute care inpatient days. Regulations located at 42 CFR 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).

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 section 1886(r) to the Act that modifies the methodology for computing the Medicare DSH payment adjustment. (For purposes of this proposed rule, we refer to these provisions collectively as section 3133 of the Affordable Care Act.) 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 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 DSH payments 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 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 MedPAC in its March 2007 Report to 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 such 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 FY 2018 and subsequent fiscal years, 1 minus the percent change in the percent of individuals who are uninsured, as determined by comparing the percent of individuals who were 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 were 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.

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 are available which are 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 the applicable 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 Medicare 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.

2. Eligibility for Empirically Justified Medicare DSH Payments and Uncompensated Care Payments

As explained 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 will 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 in the rulemaking for subsequent fiscal years, we have specified our policies for several specific classes of hospitals within the scope of section 1886(r) of the Act. In this FY 2021 IPPS/LTCH PPS proposed rule), we discuss our specific policies regarding eligibility to receive empirically justified Medicare DSH payments and uncompensated care payments for FY 2021 with respect to the following hospitals:

- *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 2019 IPPS/LTCH PPS final rule (83 FR 41402 through 41403), CMS and the State have entered into an agreement to govern payments to Maryland hospitals under a new payment model, the Maryland Total Cost of Care (TCOC) Model, which began on January 1, 2019. Under the Maryland TCOC Model, Maryland hospitals will not be paid under the IPPS in FY 2021, and will be ineligible to receive

empirically justified Medicare DSH payments and uncompensated care payments under section 1886(r) of the Act.

- *Sole community hospitals (SCHs) that are paid under their hospital-specific 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).

- *Medicare-dependent, small rural hospitals (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 that is used in the MDH payment methodology is the same IPPS Federal rate that is used in the SCH payment methodology. Section 50205 of the Bipartisan Budget Act of 2018 (Pub. L. 115-123), enacted on February 9, 2018, extended the MDH program for discharges on or after October 1, 2017, through September 30, 2022. Because MDHs are paid based on the IPPS Federal rate, they continue to be eligible to receive empirically justified Medicare DSH payments and uncompensated care payments if their DPP is at least 15 percent, and we apply the same process to determine MDHs' eligibility for empirically justified Medicare DSH and uncompensated care payments as we do for all other IPPS hospitals. Due to the

extension of the MDH program, MDHs will continue to be 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. Accordingly, 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 will calculate a Factor 3 and an uncompensated care payment amount for all MDHs, regardless of whether they are projected to be eligible for Medicare DSH payments during the fiscal year, but the denominator of Factor 3 of the uncompensated care payment methodology will be based only 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 elect to participate in the Bundled Payments for Care Improvement Advanced Initiative (BPCI Advanced) model starting October 1, 2018,* will continue to be paid under the IPPS and, therefore, are eligible to receive empirically justified Medicare DSH payments and uncompensated care payments. For further information regarding the BPCI Advanced model, we refer readers to the CMS website at: https://innovation.cms.gov/initiatives/bpci-advanced/.

- *IPPS hospitals that are participating in the Comprehensive Care for Joint Replacement Model* (80 FR 73300) continue to be paid under the IPPS and, therefore, are eligible to receive empirically justified Medicare DSH payments and uncompensated care payments.

- *Hospitals participating in the Rural Community Hospital Demonstration Program* are not eligible to receive empirically justified Medicare DSH payments and uncompensated care payments under section 1886(r) of the Act because they are not paid under the IPPS (78 FR 50625 and 79 FR 50008). The Rural Community Hospital Demonstration Program was originally authorized for a 5-year period by section 410A of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108–173), and extended for another 5-year period by sections 3123 and 10313 of the Affordable Care Act (Pub. L. 114–255). The period of performance for this 5-year extension period ended December 31, 2016. Section 15003 of the 21st Century Cures Act (Pub. L. 114–255), enacted December 13, 2016, again amended section 410A of Pub. L. 108–173 to require a 10-year extension period (in place of the 5-year extension required by the Affordable Care Act), therefore requiring an additional 5-year participation period for the demonstration program. Section 15003 of Pub. L. 114-255 also required a solicitation for applications for additional hospitals to participate in the demonstration program. At the time of issuance of this proposed rule, there are 27 hospitals participating in the demonstration program. Under the payment methodology that applies during the second 5 years of the extension period under the demonstration program, participating hospitals do not receive empirically justified Medicare DSH payments, and they are also excluded from receiving interim and final uncompensated care payments.

3. 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 Medicare 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 website at: http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2014-Transmittals-Items/R5P240.html.

4. Uncompensated Care Payments

As we 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. In this section of this proposed rule, we discuss the data sources and methodologies for computing each of these factors, our final policies for FYs 2014 through 2020, and our proposed policies for FY 2021.

a. Proposed Calculation of Factor 1 for FY 2021

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 this factor is equal to the difference between: (1) the aggregate amount of payments that would be made to subsection (d) hospitals under section 1886(d)(5)(F) of the Act if section 1886(r) of the Act did not apply for such fiscal year (as estimated by the Secretary); and (2) 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 payments 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 2020, in this FY 2021 IPPS/LTCH PPS proposed rule, in order to determine Factor 1 in the uncompensated care payment formula for FY 2021, we are proposing 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) of determining Factor 1 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 1886(r)(1) of the Act. Consistent with the policy that has applied in previous years, these estimates will not be revised or updated subsequent to the publication of our final projections in the FY 2021 IPPS/LTCH PPS final rule.

Therefore, in order to determine the two elements of proposed Factor 1 for FY 2021 (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), for this proposed rule, we used the most recently available projections of Medicare DSH payments for the fiscal year, as calculated by CMS' Office of the Actuary using the most recently filed Medicare hospital cost reports with Medicare DSH payment information and the most recent Medicare DSH patient percentages and Medicare DSH payment adjustments provided in the IPPS Impact File. The determination of the amount of DSH payments is partially based on the Office of the Actuary's Part A benefits projection model. One of the results of this model is inpatient hospital spending. Projections of DSH payments require projections for expected increases in utilization and case-mix. The assumptions that were used in making these

projections and the resulting estimates of DSH payments for FY 2018 through FY 2021 are discussed in the table titled "Factors Applied for FY 2018 through FY 2021 to Estimate Medicare DSH Expenditures Using FY 2017 Baseline."

For purposes of calculating Factor 1 and modeling the impact of this FY 2021 IPPS/LTCH PPS proposed rule, we used the Office of the Actuary's December 2019 Medicare DSH estimates, which were based on data from the September 2019 update of the Medicare Hospital Cost Report Information System (HCRIS) and the FY 2020 IPPS/LTCH PPS final rule IPPS Impact File, published in conjunction with the publication of the FY 2020 IPPS/LTCH PPS final rule. Because SCHs that are projected to be paid under their hospital-specific rate are excluded from the application of section 1886(r) of the Act, these hospitals also were excluded from the December 2019 Medicare DSH estimates. Furthermore, because section 1886(r) of the Act specifies that the uncompensated care payment is in addition to the empirically justified Medicare DSH payment (25 percent of DSH payments that would be made without regard to section 1886(r) of the Act), Maryland hospitals, which are not eligible to receive DSH payments, were also excluded from the Office of the Actuary's December 2019 Medicare DSH estimates. The 27 hospitals that are participating in the Rural Community Hospital Demonstration Program were also excluded from these estimates because, under the payment methodology that applies during the second 5 years of the extension period, these hospitals are not eligible to receive empirically justified Medicare DSH payments or interim and final uncompensated care payments.

For this proposed rule, using the data sources as previously discussed, the Office of the Actuary's December 2019 estimate for Medicare DSH payments for FY 2021 without regard to the application of section 1886(r)(1) of the Act, is approximately $14.004 billion. Therefore,

also based on the December 2019 estimate, the estimate of empirically justified Medicare DSH payments for FY 2021, with the application of section 1886(r)(1) of the Act, is approximately $3.840 billion (or 25 percent of the total amount of estimated Medicare DSH payments for FY 2021). Under § 412.l06(g)(1)(i) of the regulations, Factor 1 is the difference between these two estimates of the Office of the Actuary. Therefore, in this proposed rule, we are proposing that Factor 1 for FY 2021 would be $ 11,518,901,035.84, which is equal to 75 percent of the total amount of estimated Medicare DSH payments for FY 2021 ($15,358,534,714.46 minus $3,839,633,678.61). We note that consistent with our approach in previous rulemakings, OACT intends to use more recent data that may become available for purposes of projecting the final Factor 1 estimates for the FY 2021 IPPS/LTCH PPS final rule.

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 Midsession Review of the President's Budget. As we have in the past, for additional information on the development of the President's Budget, we refer readers to the Office of Management and Budget website at: https://www.whitehouse.gov/omb/budget. We recognize that our reliance on the economic assumptions and actuarial analysis used to develop the President's Budget in estimating Factor 1 has an impact on stakeholders who wish to replicate the Factor 1 calculation, such as modelling the relevant Medicare Part A portion of the budget, but we believe commenters are able to meaningfully comment on our proposed estimate of Factor 1 without replicating the President's Budget.

For a general overview of the principal steps involved in projecting future inpatient costs and utilization, we refer readers to the "2019 Annual Report of the Boards of Trustees of the

Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds" available on the CMS website at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/index.html?redirect=/reportstrustfunds/ under "Downloads." We note that the annual reports of the Medicare Boards of Trustees to Congress represent the Federal Government's official evaluation of the financial status of the Medicare Program. The actuarial projections contained in these reports are based on numerous assumptions regarding future trends in program enrollment, utilization and costs of health care services covered by Medicare, as well as other factors affecting program expenditures. In addition, although the methods used to estimate future costs based on these assumptions are complex, they are subject to periodic review by independent experts to ensure their validity and reasonableness.

We also refer readers to the 2017 Actuarial Report on the Financial Outlook for Medicaid for a discussion of general issues regarding Medicaid projections. (available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/MedicaidReport).

In this proposed rule, we include information regarding the data sources, methods, and assumptions employed by the actuaries in determining the OACT's estimate of Factor 1. In summary, we indicate the historical HCRIS data update OACT used to identify Medicare DSH payments, we explain that the most recent Medicare DSH payment adjustments provided in the IPPS Impact File were used, and we provide the components of all the update factors that were applied to the historical data to estimate the Medicare DSH payments for the upcoming fiscal year, along with the associated rationale and assumptions. This discussion also includes a

description of the "Other" and "Discharges" assumptions, and also provides additional information regarding how we address the Medicaid and CHIP expansion.

The Office of the Actuary's estimates for FY 2021 for this proposed rule began with a baseline of $14.004 billion in Medicare DSH expenditures for FY 2017. The following table shows the factors applied to update this baseline through the current estimate for FY 2021:

Factors Applied for FY 2018 through FY 2021 to Estimate Medicare DSH Expenditures Using FY 2017 Baseline						
FY	**Update**	**Discharges**	**Case-Mix**	**Other**	**Total**	**Estimated DSH Payment (in billions)***
2018	1.018088	0.983	1.018	1.03145	1.0508	14.716
2019	1.0185	0.9549	1.01	1.02025	1.0022	14.748
2020	1.031	0.9756	1.005	0.9961	1.0069	14.850
2021	1.031	0.9959	1.005	1.00225	1.0342	15.359

*Rounded.

In this table, the discharges column shows the increase in the number of Medicare fee-for-service (FFS) inpatient hospital discharges. The figures for FY 2018 are based on Medicare claims data that have been adjusted by a completion factor to account for incomplete claims data. The discharge figure for FY 2019 is based on preliminary data for 2019. The discharge figures for FY 2020 and FY 2021 are assumptions based on recent trends recovering back to the long-term trend and assumptions related to how many beneficiaries will be enrolled in Medicare Advantage (MA) plans. The case-mix column shows the increase in case-mix for IPPS hospitals. The case-mix figures for FY 2018 and FY 2019 are based on actual data adjusted by a completion factor. The FY 2020 and FY 2021 increases are estimates 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, and various adjustments to the payment rates that have been included over the years but are not reflected in the other columns (such as the change 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 factor for Medicaid expansion was developed using public information and statements for each State regarding its intent to implement the expansion. Based on this information, it is assumed that 55 percent of all individuals who were potentially newly eligible Medicaid enrollees in 2018 resided in States that had elected to expand Medicaid eligibility and, for 2020 and thereafter, that 58 percent of such individuals would reside in expansion States. In the future, these assumptions may change based on actual participation by States. For a discussion of general issues regarding Medicaid projections, we refer readers to the 2017 Actuarial Report on the Financial Outlook for Medicaid, which is available on the CMS website at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/MedicaidReport2017.pdf. We note that, in developing their estimates of the effect of Medicaid expansion on Medicare DSH expenditures, our actuaries have assumed that the new Medicaid enrollees are healthier than the average Medicaid recipient and, therefore, use fewer hospital services. Specifically, based on data from the President's Budget, the OACT assumed per capita spending for Medicaid beneficiaries who enrolled due to the expansion to be 50 percent of the average per capita expenditures for a pre-expansion Medicaid beneficiary due to the better health of these beneficiaries. This assumption is consistent with recent internal estimates of Medicaid per capita spending pre-expansion and post-expansion.

The following table shows the factors that are included in the "Update" column of the previous table:

FY	Market Basket Percentage	Affordable Care Act Payment Reductions	Multifactor Productivity Adjustment	Documentation and Coding	Total Update Percentage

2018	2.7	-0.75	-0.6	0.4588	1.8088
2019	2.9	-0.75	-0.8	0.5	1.85
2020	3.0	0	-0.4	0.5	3.1
2021	3.0	0	-0.4	0.5	3.1

Note: All numbers are based on the FY 2021 President's Budget projections, except for the FY 2021 percentages, which are based on the most recent forecast. We refer readers to section IV.B. of the preamble of this proposed rule for a complete discussion of the proposed changes in the inpatient hospital update for FY 2021.

b. Calculation of Proposed Factor 2 for FY 2021

(1) Background

Section 1886(r)(2)(B) of the Act establishes Factor 2 in the calculation of the uncompensated care payment. Section 1886(r)(2)(B)(ii) of the Act provides that, for FY 2018 and subsequent fiscal 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 were 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 were 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. In FY 2020 and subsequent fiscal years, there is no longer a reduction. We note that, unlike section 1886(r)(2)(B)(i) of the Act, which governed the calculation of Factor 2 for FYs 2014, 2015, 2016, and 2017, section 1886(r)(2)(B)(ii) of the Act permits the use of a data source other than the CBO estimates to determine the percent change in the rate of uninsurance beginning in FY 2018. In addition, for FY 2018 and subsequent years, the statute does not require that the estimate of the percent of individuals who are uninsured be limited to individuals who are under 65 years of age.

As we discussed in the FY 2018 IPPS/LTCH PPS final rule (82 FR 38197), in our analysis of a potential data source for the rate of uninsurance for purposes of computing Factor 2

in FY 2018, we considered the following: (a) the extent to which the source accounted for the full U.S. population; (b) the extent to which the source comprehensively accounted for both public and private health insurance coverage in deriving its estimates of the number of uninsured; (c) the extent to which the source utilized data from the Census Bureau; (d) the timeliness of the estimates; (e) the continuity of the estimates over time; (f) the accuracy of the estimates; and (g) the availability of projections (including the availability of projections using an established estimation methodology that would allow for calculation of the rate of uninsurance for the applicable Federal fiscal year). As we explained in the FY 2018 IPPS/LTCH PPS final rule, these considerations are consistent with the statutory requirement that this estimate be based on data from the Census Bureau or other sources the Secretary determines appropriate and help to ensure the data source will provide reasonable estimates for the rate of uninsurance that are available in conjunction with the IPPS rulemaking cycle. We are proposing to use the same methodology as was used in FY 2018 through FY 2020 to determine Factor 2 for FY 2021.

In the FY 2018 IPPS/LTCH PPS final rule (82 FR 38197 and 38198), we explained that we determined the source that, on balance, best meets all of these considerations is the uninsured estimates produced by CMS' Office of the Actuary (OACT) as part of the development of the National Health Expenditure Accounts (NHEA). The NHEA represents the government's official estimates of economic activity (spending) within the health sector. The information contained in the NHEA has been used to study numerous topics related to the health care sector, including, but not limited to, changes in the amount and cost of health services purchased and the payers or programs that provide or purchase these services; the economic causal factors at work in the health sector; the impact of policy changes, including major health reform; and

comparisons to other countries' health spending. Of relevance to the determination of Factor 2 is that the comprehensive and integrated structure of the NHEA creates an ideal tool for evaluating changes to the health care system, such as the mix of the insured and uninsured, because this information is integral to the well-established NHEA methodology. In this section of this proposed rule, we describe some aspects of the methodology used to develop the NHEA that were particularly relevant in estimating the percent change in the rate of uninsurance for FY 2018 through FY 2020 that we believe continue to be relevant in developing the estimate for FY 2021. A full description of the methodology used to develop the NHEA is available on the CMS website at: https://www.cms.gov/files/document/definitions-sources-and-methods.pdf.

The NHEA estimates of U.S. population reflect the Census Bureau's definition of the resident-based population, which includes all people who usually reside in the 50 States or the District of Columbia, but excludes residents living in Puerto Rico and areas under U.S. sovereignty, members of the U.S. Armed Forces overseas, and U.S. citizens whose usual place of residence is outside of the United States, plus a small (typically less than 0.2 percent of population) adjustment to reflect Census undercounts. In past years, the estimates for Factor 2 were made using the CBO's uninsured population estimates for the under 65 population. For FY 2018 and subsequent years, the statute does not restrict the estimate to the measurement of the percent of individuals under the age of 65 who are uninsured. Accordingly, as we explained in the FY 2018 IPPS/LTCH PPS proposed and final rules, we believe it is appropriate to use an estimate that reflects the rate of uninsurance in the United States across all age groups. In addition, we continue to believe that a resident-based population estimate more fully reflects the levels of uninsurance in the United States that influence uncompensated care for hospitals than an estimate that reflects only legal residents. The NHEA estimates of uninsurance are for the

total U.S. population (all ages) and not by specific age cohort, such as the population under the age of 65.

The NHEA includes comprehensive enrollment estimates for total private health insurance (PHI) (including direct and employer-sponsored plans), Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and other public programs, and estimates of the number of individuals who are uninsured. Estimates of total PHI enrollment are available for 1960 through 2018, estimates of Medicaid, Medicare, and CHIP enrollment are available for the length of the respective programs, and all other estimates (including the more detailed estimates of direct-purchased and employer-sponsored insurance) are available for 1987 through 2018. The NHEA data are publicly available on the CMS website at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/index.html.

In order to compute Factor 2, the first metric that is needed is the proportion of the total U.S. population that was uninsured in 2013. In developing the estimates for the NHEA, OACT's methodology included using the number of uninsured individuals for 1987 through 2009 based on the enhanced Current Population Survey (CPS) from the State Health Access Data Assistance Center (SHADAC). The CPS, sponsored jointly by the U.S. Census Bureau and the U.S. Bureau of Labor Statistics (BLS), is the primary source of labor force statistics for the population of the United States. (We refer readers to the website at: http://www.census.gov/programs-surveys/cps.html.) The enhanced CPS, available from SHADAC (available at: http://datacenter.shadac.org) accounts for changes in the CPS methodology over time. OACT further adjusts the enhanced CPS for an estimated undercount of Medicaid enrollees (a population that is often not fully captured in surveys that include Medicaid enrollees due to a

perceived stigma associated with being enrolled in the Medicaid program or confusion about the source of their health insurance).

To estimate the number of uninsured individuals for 2010 through 2018, the OACT extrapolates from the 2009 CPS data using data from the National Health Interview Survey (NHIS). The NHIS is one of the major data collection programs of the National Center for Health Statistics (NCHS), which is part of the Centers for Disease Control and Prevention (CDC). The U.S. Census Bureau is the data collection agent for the NHIS. The NHIS results have been instrumental over the years in providing data to track health status, health care access, and progress toward achieving national health objectives. For further information regarding the NHIS, we refer readers to the CDC website at: https://www.cdc.gov/nchs/nhis/index.htm.

The next metrics needed to compute Factor 2 are projections of the rate of uninsurance in both CY 2020 and CY 2021. On an annual basis, OACT projects enrollment and spending trends for the coming 10-year period. Those projections (currently for years 2019 through 2028) use the latest NHEA historical data, which presently run through 2018. The NHEA projection methodology accounts for expected changes in enrollment across all of the categories of insurance coverage previously listed. The sources for projected growth rates in enrollment for Medicare, Medicaid, and CHIP include the latest Medicare Trustees Report, the Medicaid Actuarial Report, or other updated estimates as produced by OACT. Projected rates of growth in enrollment for private health insurance and the uninsured are based largely on OACT's econometric models, which rely on the set of macroeconomic assumptions underlying the latest Medicare Trustees Report. Greater detail can be found in OACT's report titled "Projections of National Health Expenditure: Methodology and Model Specification," which is available on the

CMS website at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/ProjectionsMethodology.pdf.

The use of data from the NHEA to estimate the rate of uninsurance is consistent with the statute and meets the criteria we have identified for determining the appropriate data source. Section 1886(r)(2)(B)(ii) of the Act instructs the Secretary to estimate the rate of uninsurance for purposes of Factor 2 based on data from the Census Bureau or other sources the Secretary determines appropriate. The NHEA utilizes data from the Census Bureau; the estimates are available in time for the IPPS rulemaking cycle; the estimates are produced by OACT on an annual basis and are expected to continue to be produced for the foreseeable future; and projections are available for calendar year time periods that span the upcoming fiscal year. Timeliness and continuity are important considerations because of our need to be able to update this estimate annually. Accuracy is also a very important consideration and, all things being equal, we would choose the most accurate data source that sufficiently meets our other criteria.

(2) Proposed Factor 2 for FY 2021

Using these data sources and the previously described methodologies, the OACT estimates that the uninsured rate for the historical, baseline year of 2013 was 14 percent and for CYs 2020 and 2021 is 9.5 percent and 9.5 percent, respectively.[462] As required by section 1886(r)(2)(B)(ii) of the Act, the Chief Actuary of CMS has certified these estimates.

As with the CBO estimates on which we based Factor 2 in prior fiscal years, the NHEA estimates are for a calendar year. In the rulemaking for FY 2014, many commenters noted that the uncompensated care payments are made for the fiscal year and not on a calendar year basis and requested that CMS normalize the CBO estimate to reflect a fiscal year basis. Specifically,

[462] Certification of Rates of Uninsured. April 3, 2020. Available at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInPatientPPS/dsh.html.

commenters requested that CMS calculate a weighted average of the CBO estimate for October through December 2013 and the CBO estimate for January through September 2014 when determining Factor 2 for FY 2014. We agreed with the commenters that normalizing the estimate to cover FY 2014 rather than CY 2014 would more accurately reflect the rate of uninsurance that hospitals would experience during the FY 2014 payment year. Accordingly, we estimated the rate of uninsurance for FY 2014 by calculating a weighted average of the CBO estimates for CY 2013 and CY 2014 (78 FR 50633). We have continued this weighted average approach of rate of uninsurance projections for each Federal fiscal year since the FY 2014 IPPS/LTCH PPS final rule.

We continue to believe that, in order to estimate the rate of uninsurance during a fiscal year more accurately, Factor 2 should reflect the estimated rate of uninsurance that hospitals will experience during the fiscal year, rather than the rate of uninsurance during only one of the calendar years that the fiscal year spans. Accordingly, we are proposing to continue to apply the weighted average approach used in past fiscal years in order to estimate the rate of uninsurance for FY 2021. The OACT has certified this estimate of the fiscal year rate of uninsurance to be reasonable and appropriate for purposes of section 1886(r)(2)(B)(ii) of the Act. We may also consider the use of more recent data that may become available for purposes of estimating the rates of uninsurance used in the calculation of the final Factor 2 for FY 2021.

The calculation of the proposed Factor 2 for FY 2021 using a weighted average of the OACT's projections for CY 2020 and CY 2021 is as follows:

- Percent of individuals without insurance for CY 2013: 14 percent.
- Percent of individuals without insurance for CY 2020: 9.5 percent.
- Percent of individuals without insurance for CY 2021: 9.5 percent.

- Percent of individuals without insurance for FY 2021 (0.25 times 0.095) + (0.75 times 0.095): 9.5 percent

1-|((0.095 - 0.14)/0.14)| = 1 - 0.3214 = 0.6786 (67.86 percent).

For FY 2020 and subsequent fiscal years, section 1886(r)(2)(B)(ii) of the Act no longer includes any reduction to the previous calculation. Therefore, we are proposing that Factor 2 for FY 2021 would be 67.86 percent.

The proposed FY 2021 uncompensated care amount is $15,358,534,714.46x 0.6786 = $7,816,726,242.92.

Proposed FY 2021 Uncompensated Care Amount	$7,816,726,242.92

We are inviting public comments on our proposed methodology for calculating Factor 2 for FY 2021.

c. Calculation of Proposed Factor 3 for FY 2021

(1) General Background

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: (1) 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 (2) 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, the first year this provision was in effect, we considered defining the amount of uncompensated care for a hospital as the uncompensated care costs of that 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 Worksheet S–10 and the completeness of these data, we did not use Worksheet S–10 data to determine Factor 3 for FY 2014, or for FYs 2015, 2016, or 2017. Instead, we believed that the utilization of insured low-income patients, as measured by patient days, would be a better proxy for the costs of hospitals in treating the uninsured and therefore appropriate to use in calculating Factor 3 for these years. Of particular importance in our decision making was the relative newness of Worksheet S-10, which went into effect on May 1, 2010. At the time of the rulemaking for FY 2014, the most recent available cost reports would have been from FYs 2010 and 2011, which were submitted on or after May 1, 2010, when the new Worksheet S–10 went into effect. We believed that concerns about the standardization and completeness of the Worksheet S–10 data could be more acute for data collected in the first year of the Worksheet's use (78 FR 50635). In addition, we believed

that it would be most appropriate to use data elements that have been historically publicly available, subject to audit, and used for payment purposes (or that the public understands will be used for payment purposes) to determine the amount of uncompensated care for purposes of Factor 3 (78 FR 50635). At the time we issued the FY 2014 IPPS/LTCH PPS final rule, we did not believe that the available data regarding uncompensated care from Worksheet S–10 met these criteria and, therefore, we believed they were not reliable enough to use for determining FY 2014 uncompensated care payments. For FYs 2015, 2016, and 2017, the cost reports used for calculating uncompensated care payments (that is, FYs 2011, 2012, and 2013) were also submitted prior to the time that hospitals were on notice that Worksheet S–10 could be the data source for calculating uncompensated care payments. Therefore, we believed it was also appropriate to use proxy data to calculate Factor 3 for these years. We indicated our belief that Worksheet S–10 could ultimately serve as an appropriate source of more direct data regarding uncompensated care costs for purposes of determining Factor 3 once hospitals were submitting more accurate and consistent data through this reporting mechanism.

In the FY 2018 IPPS/LTCH PPS final rule (82 FR 38202), we stated that we could no longer conclude that alternative data to the Worksheet S–10 are available for FY 2014 that are a better proxy for the costs of subsection (d) hospitals for treating individuals who are uninsured. Hospitals were on notice as of FY 2014 that Worksheet S–10 could eventually become the data source for CMS to calculate uncompensated care payments. Furthermore, hospitals' cost reports from FY 2014 had been publicly available for some time, and CMS had analyses of Worksheet S–10, conducted both internally and by stakeholders, demonstrating that Worksheet S–10 accuracy had improved over time. Analyses performed by MedPAC had already shown that the correlation between audited uncompensated care data from 2009 and the data from the FY 2011

Worksheet S–10 was over 0.80, as compared to a correlation of approximately 0.50 between the audited uncompensated care data and 2011 Medicare SSI and Medicaid days. Based on this analysis, MedPAC concluded that use of Worksheet S–10 data was already better than using Medicare SSI and Medicaid days as a proxy for uncompensated care costs, and that the data on Worksheet S–10 would improve over time as the data are actually used to make payments (81 FR 25090). In addition, a 2007 MedPAC analysis of data from the Government Accountability Office (GAO) and the American Hospital Association (AHA) had suggested that Medicaid days and low-income Medicare days are not an accurate proxy for uncompensated care costs (80 FR 49525).

Subsequent analyses from Dobson/DaVanzo, originally commissioned by CMS for the FY 2014 rulemaking and updated in later years, compared Worksheet S–10 and IRS Form 990 data and assessed the correlation in Factor 3s derived from each of the data sources. Our analyses on balance led us to believe that we had reached a tipping point in FY 2018 with respect to the use of the Worksheet S–10 data. We refer readers to the FY 2018 IPPS/LTCH PPS final rule (82 FR 38201 through 38203) for a complete discussion of these analyses.

We found further evidence for this tipping point when we examined changes to the FY 2014 Worksheet S–10 data submitted by hospitals following the publication of the FY 2017 IPPS/LTCH PPS final rule. In the FY 2017 IPPS/LTCH PPS final rule, as part of our ongoing quality control and data improvement measures for the Worksheet S–10, we referred readers to Change Request 9648, Transmittal 1681, titled "The Supplemental Security Income (SSI)/Medicare Beneficiary Data for Fiscal Year 2014 for Inpatient Prospective Payment System (IPPS) Hospitals, Inpatient Rehabilitation Facilities (IRFs), and Long Term Care Hospitals (LTCHs)," issued on July 15, 2016 (available at: https://www.cms.gov/Regulations-and-

Guidance/Guidance/Transmittals/Downloads/R1681OTN.pdf). In this transmittal, as part of the process for ensuring complete submission of Worksheet S–10 by all eligible DSH hospitals, we instructed MACs to accept amended Worksheets S–10 for FY 2014 cost reports submitted by hospitals (or initial submissions of Worksheet S–10 if none had been submitted previously) and to upload them to the Health Care Provider Cost Report Information System (HCRIS) in a timely manner. The transmittal stated that, for revisions to be considered, hospitals were required to submit their amended FY 2014 cost report containing the revised Worksheet S–10 (or a completed Worksheet S–10 if no data were included on the previously submitted cost report) to the MAC no later than September 30, 2016. For the FY 2018 IPPS/LTCH PPS proposed rule (82 FR 19949 through 19950), we examined hospitals' FY 2014 cost reports to see if the Worksheet S-10 data on those cost reports had changed as a result of the opportunity for hospitals to submit revised Worksheet S–10 data for FY 2014. Specifically, we compared hospitals' FY 2014 Worksheet S–10 data as they existed in the first quarter of CY 2016 with data from the fourth quarter of CY 2016. We found that the FY 2014 Worksheet S–10 data had changed over that time period for approximately one quarter of hospitals that receive uncompensated care payments. The fact that the Worksheet S–10 data changed for such a significant number of hospitals following a review of the cost report data they originally submitted and that the revised Worksheet S-10 information is available to be used in determining uncompensated care costs contributed to our belief that we could no longer conclude that alternative data are available that are a better proxy than the Worksheet S-10 data for the costs of subsection (d) hospitals for treating individuals who are uninsured.

We also recognized commenters' concerns that, in using Medicaid days as part of the proxy for uncompensated care, 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. Because the earliest Medicaid expansions under the Affordable Care Act began in 2014, the 2011, 2012, and 2013 Medicaid days used to calculate uncompensated care payments in FYs 2015, 2016, and 2017 are the latest available data on Medicaid utilization that do not reflect the effects of these Medicaid expansions. Accordingly, if we had used only low-income insured days to estimate uncompensated care for FY 2018, we would have needed to hold the time period of these data constant and use data on Medicaid days from 2011, 2012, and 2013 in order to avoid the risk of any redistributive effects arising from the decision to expand Medicaid in certain States. As a result, we would have been using older data that may provide a less accurate proxy for the level of uncompensated care being furnished by hospitals, contributing to our growing concerns regarding the continued use of low-income insured days as a proxy for uncompensated care costs in FY 2018.

To address concerns raised by commenters regarding a lack of clear and concise line level instructions, CMS issued Transmittal 10, which clarified and revised the instructions for reporting charity care on Worksheet S-10. For a discussion of the revisions and clarifications included in Transmittal 10, we refer the reader to the FY 2020 IPPS/LTCH PPS final rule (84 FR 42360). On September 29, 2017, we issued Transmittal 11, which clarified the definitions and instructions for uncompensated care, non-Medicare bad debt, non-reimbursed Medicare bad debt, and charity care, as well as modifying the calculations relative to uncompensated care costs and adding edits to ensure the integrity of the data reported on Worksheet S-10. Transmittal 11 is available for download on the CMS website at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R11p240.pdf. We further clarified that full or

partial discounts given to uninsured patients who meet the hospital's charity care policy or financial assistance policy/uninsured discount policy (hereinafter referred to as Financial Assistance Policy or FAP) may be included on Line 20, Column 1 of Worksheet S-10. These clarifications applied to cost reporting periods beginning on or after October 1, 2013. We also modified the application of the CCR. We specified that the CCR will not be applied to the deductible and coinsurance amounts for insured patients approved for charity care and non-reimbursed Medicare bad debt. The CCR will be applied to the charges for uninsured patients approved for charity care or an uninsured discount, non-Medicare bad debt, and charges for noncovered days exceeding a length of stay limit imposed on patients covered by Medicaid or other indigent care programs. As discussed in more detail in the FY 2020 IPPS/LTCH PPS final rule (84 FR 42360 and 42361), we have also provided opportunities for hospitals to submit revisions to their Worksheet S-10 data for FY 2014 and FY 2015 cost reports.

As discussed in the FY 2019 IPPS/LTCH PPS final rule (83 FR 41424), due to the overwhelming feedback from commenters emphasizing the importance of audits in ensuring the accuracy and consistency of data reported on the Worksheet S-10, we expected to begin audits of the Worksheet S-10 in the Fall of 2018. The audit protocol instructions were still under development at the time of the FY 2019 IPPS/LTCH PPS final rule; yet, we noted the audit protocols would be provided to the MACs in advance of the audit. Once the audit protocol instructions were complete, we began auditing the Worksheet S-10 data for selected hospitals in the Fall of 2018 so that the audited uncompensated care data from these hospitals would be available in time for use in the FY 2020 IPPS/LTCH PPS proposed rule. The audits began with 1 year of data (that is, FY 2015 cost reports) in order to maximize the available audit resources and not spread those audit resources over multiple years, potentially diluting their effectiveness.

We chose to begin the audits with the FY 2015 cost reports primarily because this was the most recent year of data that we had broadly allowed to be resubmitted by hospitals, and many hospitals had already made considerable efforts to amend their FY 2015 reports in preparation for the FY 2019 rulemaking. We also considered that we had used the FY 2015 data as part of the calculation of the FY 2019 uncompensated care payments; therefore, the data had been subject to public comment and scrutiny.

(2) Background on the Methodology Used to Calculate Factor 3 for FY 2020

Section 1886(r)(2)(C) of the Act governs both the selection of the data to be used in calculating Factor 3, and 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 2020 IPPS/LTCH PPS proposed rule (84 FR 19418 and 19419), we proposed to use audited FY 2015 data to calculate Factor 3 for FY 2020. Given that we had conducted audits of the FY 2015 Worksheet S-10 data and had previously used the FY 2015 data to determine uncompensated care payments, and the fact that the FY 2015 data were the most recent data that we had allowed to be resubmitted to date, we believed, on balance, that the FY 2015 Worksheet S-10 data were the best available data to use for calculating Factor 3 for FY 2020.

In the FY 2020 IPPS/LTCH PPS proposed rule, we recognized that, for FY 2019, we used 3 years of data in the calculation of Factor 3 in order to smooth over anomalies between cost reporting periods and to mitigate undue fluctuations in the amount of uncompensated care payments from year to year. However, we stated that, for FY 2020, we believed mixing audited and unaudited data for individual hospitals by averaging multiple years of data could potentially lead to a less smooth result, which would be counter to our original goal in using 3 years of data. As we stated in the FY 2020 IPPS/LTCH PPS proposed rule, to the extent that the audited FY 2015 data for a hospital are relatively different from its unaudited FY 2014 data and/or its unaudited FY 2016 data, we potentially would be diluting the effect of our considerable auditing efforts and introducing unnecessary variability into the calculation if we continued to use 3 years of data to calculate Factor 3. As an example, we noted that approximately 10 percent of audited hospitals had more than a $20 million difference between their audited FY 2015 data and their unaudited FY 2016 data.

Although we proposed to use the Worksheet S-10 data from the FY 2015 cost reports to calculate Factor 3 for FY 2020, we acknowledged that some hospitals had raised concerns regarding some of the adjustments made to the FY 2015 cost reports following the audits of those cost reports (for example adjustments made to Line 22 of Worksheet S-10). In particular, hospitals had raised concerns regarding the instructions in effect for FY 2015, especially compared to the reporting instructions that were effective for cost reporting periods beginning on or after October 1, 2016, contending that some adjustments would not have been made if CMS had chosen as an alternative to audit the FY 2017 reports. Accordingly, we sought public comments on whether the changes in the reporting instructions between the FY 2015 cost reports and the FY 2017 cost reports had resulted in a better common understanding among hospitals of how to report uncompensated care costs and improved relative consistency and accuracy across hospitals in reporting these costs. We also sought public comments on whether, due to the changes in the reporting instructions, we should use a single year of uncompensated care cost data from the FY 2017 reports, instead of the FY 2015 reports, to calculate Factor 3 for FY 2020.

In the FY 2020 IPPS/LTCH PPS final rule (84 FR 42368), we finalized our proposal to use the FY 2015 Worksheet S-10 cost report data in the methodology for determining Factor 3 for FY 2020. Although some commenters expressed support for the alternative policy of using the FY 2017 Worksheet S-10 data to determine each hospital's share of uncompensated care costs in FY 2020, given the feedback from commenters in response to both the FY 2019 and FY 2020 IPPS/LTCH PPS proposed rules, emphasizing the importance of audits in ensuring the accuracy and consistency of data reported on the Worksheet S-10, we concluded that the FY 2015 Worksheet S-10 data were the best available audited data to be used in determining

Factor 3 for FY 2020. We also noted that we had begun auditing the FY 2017 data in July 2019, with the goal of having the FY 2017 audited data available for future rulemaking.

With respect to the Worksheet S–10 data, we indicated our belief that the definition of uncompensated care adopted in FY 2018 was still appropriate because it incorporates the most commonly used factors within uncompensated care as reported by stakeholders, including charity care costs and non-Medicare bad debt costs. Therefore, for purposes of calculating Factor 3 and uncompensated care costs for FY 2020, we again defined ''uncompensated care'' as the amount on Line 30 of Worksheet S–10, which is the cost of charity care (Line 23) and the cost of non-Medicare bad debt and non-reimbursable Medicare bad debt (Line 29).

In the FY 2020 IPPS/LTCH PPS final rule, we continued to apply the following policies as part of the Factor 3 methodology: (1) the merger policies that were initially adopted in the FY 2015 IPPS/LTCH PPS final rule (79 FR 50020); (2) the policy for providers with multiple cost reports, beginning in the same fiscal year, of using the longest cost report and annualizing Medicaid data and uncompensated care data if a hospital's cost report does not equal 12 months of data; (3) the policy for the rare cases where a provider has multiple cost reports, beginning in the same fiscal year, but one report also spans the entirety of the following fiscal year, such that the hospital has no cost report for that fiscal year, of using the cost report that spans both fiscal years for the latter fiscal year; and (4) the policies regarding the application of statistical trim methodologies to potentially aberrant CCRs and potentially aberrant uncompensated care costs reported on the Worksheet S–10.

In the FY 2020 IPPS/LTCH PPS final rule (84 FR 19419), we finalized a modified new hospital policy for new hospitals that did not have data for the cost reporting period(s) used in the Factor 3 calculation for FY 2020. Generally, new hospitals do not yet have available data to

project their eligibility for DSH payments because there is a lag until the SSI ratio and Medicaid ratio become available. However, we noted that there are some hospitals (that is, hospitals with CCNs established after October 1, 2015) that have a preliminary projection of being eligible for DSH payments based on their most recent available disproportionate patient percentages. Under the modified policy adopted for FY 2020, new hospitals that are eligible for Medicare DSH may receive interim empirically justified DSH payments. However, because these hospitals do not have a FY 2015 cost report to use in the Factor 3 calculation and the projection of eligibility for DSH payments is still preliminary, the MAC will make a final determination concerning whether the hospital is eligible to receive Medicare DSH payments at cost report settlement based on its FY 2020 cost report. If the hospital is ultimately determined to be eligible for Medicare DSH payments for FY 2020, the hospital will receive an uncompensated care payment calculated using a Factor 3, where the numerator is the uncompensated care costs reported on Worksheet S-10 of the hospital's FY 2020 cost report, and the denominator is the sum of the uncompensated care costs reported on Worksheet S–10 of the FY 2015 cost reports for all DSH-eligible hospitals. In the FY 2020 IPPS/LTCH PPS final rule, we noted that, given the time period of the data used to calculate Factor 3, any hospitals with a CCN established after October 1, 2015, would be considered new and subject to this policy in FY 2020.

For a discussion of the policy that we finalized for FY 2020 for new Puerto Rico hospitals, we refer readers to the FY 2020 IPPS/LTCH PPS final rule (84 FR 42370 and 42371). In brief, Puerto Rico hospitals that do not have a FY 2013 cost report are considered new hospitals and subject to the new hospital policy, as previously discussed. Specifically, the numerator of the Factor 3 calculation will be the uncompensated care costs reported on Worksheet S–10 of the hospital's FY 2020 cost report and the denominator is the same

denominator that is determined prospectively for purposes of determining Factor 3 for all DSH-eligible hospitals. We stated that we believe the discussion in the FY 2020 IPPS/LTCH PPS proposed rule of our intent to determine Factor 3 for these hospitals using their uncompensated care costs gave new Puerto Rico hospitals sufficient time to take the steps necessary to ensure that their uncompensated care costs for FY 2020 are accurately reported on their FY 2020 Worksheet S–10. In addition, we indicated that we expect MACs to review FY 2020 reports from new hospitals, as necessary, which will address past commenters' concerns regarding the need for further review of Puerto Rico hospitals' uncompensated care data before these data are used to determine Factor 3.

In the FY 2020 IPPS/LTCH PPS final rule (83 FR 42371), for Indian Health Service and Tribal hospitals, and subsection (d) Puerto Rico hospitals that have a FY 2013 cost report, we continued the policy we first adopted for FY 2018 of substituting data regarding FY 2013 low-income insured days for the Worksheet S–10 data when determining Factor 3. As we discussed in the FY 2018 IPPS/LTCH PPS final rule (82 FR 38209), the use of data from Worksheet S-10 to calculate the uncompensated care amount for Indian Health Service and Tribal hospitals may jeopardize these hospitals' uncompensated care payments due to their unique funding structure. With respect to Puerto Rico hospitals that would not be subject to the new hospital policy, we indicated that we continued to agree with concerns raised by commenters that the uncompensated care data reported by these hospitals need to be further examined before the data are used to determine Factor 3. Accordingly, for these hospitals, we determined Factor 3 based on Medicaid days from FY 2013 and the most recent update of SSI days. The aggregated amount of uncompensated care that is used in the Factor 3 denominator for these hospitals continued to be based on the low-income patient proxy; that is, the aggregate amount of

uncompensated care determined for all DSH-eligible hospitals using the low-income insured days proxy. We stated our belief that this approach was appropriate as the FY 2013 data reflect the most recent available information regarding these hospitals' low-income insured days before any expansion of Medicaid. In addition, because we continued to use 1 year of insured low-income patient days as a proxy for uncompensated care for Puerto Rico hospitals and residents of Puerto Rico are not eligible for SSI benefits, we continued to use a proxy for SSI days for Puerto Rico hospitals consisting of 14 percent of the hospital's Medicaid days, as finalized in the FY 2017 IPPS/LTCH PPS final rule (81 FR 56953 through 56956).

Therefore, for FY 2020, we computed Factor 3 for each hospital by—

Step 1: Selecting the provider's longest cost report from its Federal fiscal year (FFY) 2015 cost reports. (Alternatively, in the rare case when the provider has no FFY 2015 cost report because the cost report for the previous Federal fiscal year spanned the FFY 2015 time period, the previous Federal fiscal year cost report would be used in this step.)

Step 2: Annualizing the uncompensated care costs (UCC) from Worksheet S–10 Line 30, if the cost report is more than or less than 12 months. (If applicable, use the statewide average CCR (urban or rural) to calculate uncompensated care costs.)

Step 3: Combining annualized uncompensated care costs for hospitals that merged.

Step 4: Calculating Factor 3 for Indian Health Service and Tribal hospitals and Puerto Rico hospitals that have a FY 2013 cost report using the low-income insured days proxy based on FY 2013 cost report data and the most recent available SSI ratio (or, for Puerto Rico hospitals, 14 percent of the hospital's FY 2013 Medicaid days). (Alternatively, in the rare case when the provider has no FFY applicable cost report because the cost report for the previous Federal fiscal year spanned the time period, the previous Federal fiscal year cost report would be

used in this step.) The denominator is calculated using the low-income insured days proxy data from all DSH eligible hospitals. Consistent with the policy adopted in the FY 2019 IPPS/LTCH PPS final rule, if a hospital did not have both Medicaid days for FY 2013 and SSI days for FY 2017 available for use in the calculation of Factor 3 in Step 4, we considered the hospital not to have data available for Step 4.

Step 5: Calculating Factor 3 for the remaining DSH eligible hospitals using annualized uncompensated care costs (Worksheet S–10 Line 30) based on FY 2015 cost report data (from Step 3). The hospitals for which Factor 3 was calculated in Step 4 are excluded from this calculation.

We amended the regulations at § 412.106 by adding a new paragraph (g)(1)(iii)(C)(*6*) to reflect the methodology for computing Factor 3 for FY 2020.

(3) Proposed Methodology for Calculating Factor 3 for FY 2021 and Subsequent Fiscal Years

(a) Proposal to Use Audited FY 2017 Data to Calculate Factor 3 for FY 2021

Since the publication of the FY 2020 IPPS/LTCH PPS final rule, we have continued to monitor the reporting of Worksheet S-10 data in order to determine the most appropriate data to use in the calculation of Factor 3 for FY 2021. Audits of FY 2017 cost reports began in June 2019 and those audited reports are now available, in time for the development of this proposed rule. Feedback from the audits of the FY 2015 reports and lessons learned were incorporated into the audit process for the FY 2017 reports. We again chose to audit 1 year of data (that is, FY 2017) in order to maximize the available audit resources and not spread those audit resources over multiple years, potentially diluting their effectiveness.

Given that the FY 2017 Worksheet S-10 data were submitted under the revised cost reporting instructions that were effective on October 1, 2017, and we have also undertaken

provider outreach regarding potentially aberrant data in FY 2017 reports and conducted audits of these data (84 FR 42371), we believe, on balance, that the FY 2017 Worksheet S-10 data are the best available data to use for calculating Factor 3 for FY 2021. For a detailed discussion of the cost reporting instruction changes between FY 2015 and FY 2017 reports, we refer the reader to the FY 2020 IPPS/LTCH PPS final rule (84 FR 42368 and 42369). For the reasons discussed in the FY 2020 IPPS/LTCH PPS proposed and final rules (84 FR 19419 and 84 FR 42364), we continue to believe that mixing audited and unaudited data for individual hospitals by averaging multiple years of data could potentially lead to a less smooth result. To the extent that the audited FY 2017 data for a hospital are relatively different from its FY 2015 data (whether audited or unaudited) and/or its unaudited FY 2016 data, we potentially would be diluting the effect of the revisions to the cost reporting instructions and our considerable auditing efforts, while introducing unnecessary variability into the calculation if we were to use multiple years of data to calculate Factor 3 for FY 2021. We recognize that the FY 2015 reports include audited data for some hospitals, however, the FY 2017 cost reports are the most recent year of audited data and, as previously discussed reflect the revisions to the Worksheet S-10 cost report instructions that were effective on October 1, 2017.

Accordingly, we are proposing to use a single year of Worksheet S–10 data from FY 2017 cost reports to calculate Factor 3 in the FY 2021 methodology for all eligible hospitals with the exception of Indian Health Service (IHS) and Tribal hospitals and Puerto Rico hospitals. As discussed in a later section, we are proposing to continue to use the low-income insured days proxy to calculate Factor 3 for these hospitals for one more year. We note that the proposed uncompensated care payments to hospitals whose FY 2017 Worksheet S–10 data have been audited represent approximately 65 percent of the proposed total uncompensated care payments

for FY 2021. For purposes of this FY 2021 proposed rule, we have used a HCRIS extract updated through February 19, 2020. We note that we intend to use the March 2020 update of HCRIS for the FY 2021 final rule and the respective March updates for all future final rules. However, we invite the public to submit comments on this intention regarding the use of the March update of HCRIS, and we may also consider the use of more recent data that may become available after March 2020, but prior to the development of the final rule, if appropriate, for purposes of calculating the final Factor 3 for purposes of the FY 2021 IPPS/LTCH PPS final rule.

(b) Proposal to Use Most Recent Available Single Year of Audited Worksheet S-10 Data to Calculate Factor 3 for All Subsequent Fiscal Years

While the number of audited hospitals may change from year to year depending on audit experience and the availability of audit resources, we expect the Worksheet S-10 data for an increasing number of hospitals will be audited in future cost reporting years. As a result, we have confidence that the best available data in future years will be the Worksheet S-10 data for cost reporting years for which audits have been conducted. In addition, we believe that establishing a policy that would apply not only for FY 2021, but also for all subsequent fiscal years would help providers have greater predictability for planning purposes. Therefore, we are proposing that for FY 2022 and all subsequent fiscal years, we would use the most recent single year of cost report data that have been audited for a significant number of hospitals receiving substantial Medicare uncompensated care payments to calculate Factor 3 for all eligible hospitals, with the exception of Indian Health Service and Tribal hospitals. We note that we intend to consider the comments received on this proposed rule, and may revisit this proposal for FY 2022 and subsequent fiscal years either in the final rule or through future rulemaking.

Given the unique nature of IHS and Tribal Hospitals and of the patient populations they serve, we believe it may be appropriate to restructure Medicare DSH payments and uncompensated care payments to these hospitals beginning in FY 2022. As discussed in prior rulemaking (for example, 82 FR 38188), the principal mission of the IHS is the provision of health care to American Indians and Alaska Natives throughout the United States. In carrying out that mission, IHS operates under two primary authorizing statutes. The first statute, the Snyder Act, authorizes IHS to expend such moneys as Congress may determine from time to time appropriate for the conservation of the health of American Indians or Alaska Natives. We refer readers to 25 U.S.C. 13 (providing that the Bureau of Indian Affairs (BIA) will expend funds as appropriated for, among other things, the conservation of health of American Indians and Alaska Natives); and 42 U.S.C. 2001(a) (transferring the responsibility for American Indian and Alaska Native health care from BIA to HHS). The second statute, the Indian Health Care Improvement Act (IHCIA), established IHS as an agency within the Public Health Service of HHS and provides authority for numerous programs to address particular health initiatives for American Indians and Alaska Natives, such as alcohol and substance abuse and diabetes (25 U.S.C. 1601 et seq.). IHS and Tribal hospitals are charged with addressing the health of American Indians and Alaska Natives and are uniquely situated to provide services to this population.

When Congress was considering reductions to the Medicare DSH payments and the creation of the Medicare uncompensated care payments under section 3133 the Affordable Care Act, one significant source of available information was the analysis done by the Medicare Payment Advisory Commission (MedPAC) in its March 2007 Report to the Congress. We note that section 1886(r)(1) of the Act explicitly refers to this March 2007 Report to Congress as the

basis for reducing DSH payments to 25 percent of the amount that would otherwise be paid under section 1886(d)(5)(F) of the Act. We have reviewed MedPAC's analysis in the March 2007 Report to Congress and it is not apparent that MedPAC was focused on the unique aspects of IHS and Tribal hospitals described above when developing its recommendations for possible changes to DSH payments. Rather, it appears that MedPAC's analysis was focused on broader underlying issues and hospitals more generally.

Given the unique nature of IHS and Tribal hospitals, and the fact that we do not believe that the DSH analysis available to Congress at the time section 3133 of the Affordable Care Act was being developed was focused on the specific circumstances of these hospitals, we believe it may be appropriate, beginning in FY 2022, to use our authority under section 1886(d)(5)(I)(i) of the Act to create an exception for IHS and Tribal hospitals from Medicare DSH payments under 1886(d)(5)(F), as amended by section 3133 of the Affordable Care Act. This exception would also have the consequence that IHS and Tribal hospitals would be excluded from the calculation of Medicare uncompensated care payments under 1886(r). Concurrently, we believe it may be appropriate to use our authority under section 1886(d)(5)(I)(i) to adjust payments to IHS and Tribal hospitals through the creation of a new IHS and Tribal hospital Medicare DSH payment. The methodology for determining this IHS and Tribal hospital Medicare DSH payment would mirror the calculation of the Medicare DSH payment under 1886(d)(5)(F) except that the payment would be determined at 100 percent of the calculated amount rather than 25 percent of the calculated amount as required under section 3133 of the Affordable Care Act. We seek comment on this potential restructuring of the Medicare DSH and uncompensated care payments to IHS and Tribal hospitals beginning in FY 2022. We also intend to consider input received on this issue through consultation with IHS and Tribal hospitals.

(c) Proposed Definition of "Uncompensated Care"

We continue to believe that the definition of "uncompensated care" first adopted in FY 2018 when we started to incorporate data from Worksheet S-10 into the determination of Factor 3 and that was used again in both FY 2019 and FY 2020 is appropriate, as it incorporates the most commonly used factors within uncompensated care as reported by stakeholders, namely, charity care costs and bad debt costs, and correlates to Line 30 of Worksheet S-10. Therefore, we are proposing that, for purposes of determining uncompensated care costs and calculating Factor 3 for FY 2021 and subsequent fiscal years, "uncompensated care" would continue to be defined as the amount on Line 30 of Worksheet S–10, which is the cost of charity care (Line 23) and the cost of non-Medicare bad debt and non-reimbursable Medicare bad debt (Line 29). We refer readers to the FY 2020 IPPS/LTCH PPS rule (84 FR 42369 and 42370), for a detailed discussion of additional topics related to definition of uncompensated care.

In the FY 2020 IPPS/LTCH PPS final rule, we stated that, we would attempt to address commenters' concerns regarding the Worksheet S-10 through future cost report clarifications to further improve and refine the information that is reported on Worksheet S–10 in order to support collection of the information necessary to implement section 1886(r)(2) of the Act. (84 FR 42370). We note that the Paper Reduction Act (PRA) package for Form CMS-2552–10 (OMB Control Number 0938–0050, expiration date March 31, 2022) offers an additional opportunity to comment on the cost reporting instructions. For further information regarding PRA, we refer the reader to the CMS website at: https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995.

(d) Proposed Changes to the Methodology for Calculating Factor 3 for FY 2021 and Subsequent Fiscal Years

The proposed changes to the methodology for calculating Factor 3 include the following:

- *Merger Multiplier for Acquired Hospital Data*

In the FY 2015 IPPS/LTCH PPS final rule, we defined a merger as an acquisition where the Medicare provider agreement of one hospital is subsumed into the provider agreement of the surviving provider (79 FR 50020). In that final rule, we adopted a policy for calculating Factor 3 for hospitals that undergo a merger during or after the time period of the data that is used in the Factor 3 calculations, as well as a separate policy for a merger that occurs after the development of the final rule for the applicable fiscal year. A proposed policy for newly merged hospitals is discussed in the next section. In the FY 2019 IPPS/LTCH PPS final rule, we finalized a policy for determining the uncompensated care costs of hospitals that have multiple cost reporting periods starting in the same fiscal year of using the longest cost report beginning in the applicable fiscal year and annualizing the uncompensated care data if a hospital's cost report does not equal 12 months of data (83 FR 41427). This policy applied for all hospitals, including those involved in a merger. However, taking into consideration past comments regarding mergers, including comments on the FY 2019 IPPS/LTCH PPS proposed rule which suggested that we not annualize the uncompensated care costs data provided in short cost reporting periods for acquired hospitals because their uncompensated care costs for the remaining part of year are included in the new combined hospital's cost report (83 FR 41427), we are proposing to modify the annualization policy that was finalized in FY 2019 with respect to merged hospitals.

We note that for most mergers, the effective date of the merger coincides with the cost reporting end date for the hospital that is being acquired. In effect, this means that the FY 2015 merger policy of combining uncompensated care costs (UCC) across CCNs results in adding together data reported on the cost report for two different CCNs (the acquired hospital and the

surviving hospital) to estimate the merged hospital's post-merger total UCC. For mergers with a recent merger effective date, such as a merger in Federal fiscal year 2019 (that is, a merger after the period of the FY 2017 cost reports we are proposing to use for the Factor 3 calculation), we continue to believe the current policy of annualizing and combining across historical cost reports produces the best available estimate for post-merger total UCC. For example, if the acquired hospital's FY 2017 cost report includes less than 12 months of data, we would annualize the data to reflect a full 12 months of data. Similarly, in this example, if the surviving hospital's cost report includes less than 12 months of data, we would annualize its uncompensated care data. However, as discussed below, we are proposing a modification to this policy when the merger effective date occurs partway through the surviving hospital's cost reporting period.

In some mergers, the merger effective date does not coincide with the start date for the surviving hospital's cost reporting period. When the merger effective date does not coincide with the start date of the surviving hospital's cost reporting period, the policy of annualizing the acquired hospital's data before combining data across hospital cost reports could substantially overestimate the acquired hospital's UCC, given that the surviving hospital's cost report reflects the UCC incurred by the acquired hospital during the portion of the year after the merger effective date. In other words, when the merger effective date is partway through the surviving hospital's cost reporting period, annualizing acquired hospital's data may double-count UCC for the portion of the year that overlaps with the remainder of the surviving hospital's cost reporting period.

Accordingly, when the merger effective date occurs partway through the surviving hospital's cost reporting period, to more accurately estimate UCC for the hospitals involved in a merger, we are proposing not to annualize the acquired hospital's data. Further, we are proposing

to use only the portion of the acquired hospital's unannualized UCC data that reflects the UCC incurred prior to the merger effective date, but after the start of the surviving hospital's current cost reporting period. Specifically, we are proposing to calculate a multiplier to be applied to an acquired hospital's UCC when the merger effective date occurs partway through the surviving hospital's cost reporting period. This multiplier will represent the portion of the UCC data from the acquired hospital that should be incorporated with the surviving hospital's data to determine UCC for purposes of determining Factor 3 for the surviving hospital. This multiplier is obtained by calculating the number of days between the start of the applicable cost reporting period for the surviving hospital and the merger effective date, and then dividing this result by the total number of days in the reporting period of the acquired hospital. Applying this multiplier to the acquired hospital's unannualized UCC data will determine the final portion of the acquired hospital's UCC that should be added to that of the surviving hospital for purposes of determining Factor 3.

As an example, if the cost reporting period start dates of the acquired and surviving hospitals align and a merger occurs halfway through the surviving hospital's cost reporting period (for example, the hospital's fiscal year), then ultimately, the cost report for the surviving hospital for that fiscal year would already reflect half a year of the acquired hospital's UCC (because the merger occurred halfway through the surviving hospital's cost reporting period and the UCC data reported by the surviving hospital incorporate any UCC incurred by the acquired hospital during the second half of the fiscal year). For illustrative purposes, consider that the cost reporting period start dates of the acquired and surviving hospitals are 10/01/2016; the cost reporting period end date of the acquired hospital is 06/30/2017; and the merger acquisition date is 07/01/2017. Thus, there are 273 days between the start of the cost reporting period of the surviving hospital and the merger effective date, and the cost reporting period of the acquired

hospital is 273 days. The multiplier, as previously defined, would be 1 (273 days divided by 273 days) and all of the acquired hospital's unannualized UCC data for the period 10/01/2016 to 06/30/2017 would be added to that of the surviving hospital for purposes of calculating Factor 3 for FY 2021. It is not necessary to annualize the acquired hospital's data from its short cost report, because the UCC incurred by the acquired hospital for the remainder of the surviving hospital's fiscal year post-merger (07/01/2017 to 09/30/2017) are already included in the UCC data reported by the surviving hospital for the cost reporting period ending on 09/30/2017.

As another example, assume the merger effective date is the same as the start date for the surviving hospital's cost reporting period and the surviving hospital's cost reporting period is 12 months long. In this example, we believe it would not be necessary to combine uncompensated care costs across multiple cost reports, because the surviving hospital's cost report already reflects 12 months of uncompensated care costs for the merged hospital. In this example, the multiplier would be 0 because there are 0 days between the start of the surviving hospital's cost reporting period and the merger effective date, and there would be no need to combine data from the acquired hospital given that the surviving hospital's cost report reflects all post-merger UCC data for the acquired hospital.

- *Newly Merged Hospitals*

We propose to continue to treat hospitals that merge after the development of the final rule similar to new hospitals. As explained in the FY 2015 IPPS/LTCH PPS final rule, for these newly merged hospitals, we do not have data currently available to calculate a Factor 3 amount that accounts for the merged hospital's uncompensated care burden (79 FR 50021). In the FY 2015 IPPS/LTCH PPS final rule, we finalized a policy under which Factor 3 for hospitals that we do not identify as undergoing a merger until after the public comment period and

additional review period following the publication of the final rule or that undergo a merger during the fiscal year would be recalculated similar to new hospitals (79 FR 50021 and 50022).

Consistent with the policy adopted in the FY 2015 IPPS/LTCH PPS final rule, we are proposing to treat newly merged hospitals in a similar manner as new hospitals, such that the newly merged hospital's final uncompensated care payment would be determined at cost report settlement where the numerator of the newly merged hospital's Factor 3 would be based on the cost report of only the surviving hospital (that is, the newly merged hospital's cost report) for the current fiscal year. However, if the hospital's cost reporting period includes less than 12 months of data, we propose that the newly merged hospital's cost report's data would be annualized for purposes of the Factor 3 calculation. We note that we are not proposing that the multiplier calculation discussed previously would be used, as that would only be necessary for estimating post-merger data using historical reports. The acquired hospital's uncompensated care payment for the fiscal year during which the merger occurs would be determined using the prospectively determined Factor 3 amount for the acquired hospital and then pro rated, if applicable. We refer the reader to the detailed discussion in the FY 2015 IPPS/LTCH PPS rule regarding the calculation of pro rata uncompensated care payments (79 FR 50151 through 50153).

Consistent with past policy, we also are proposing that the interim uncompensated care payments for the newly merged hospital would be based only on the data for the surviving hospital's CCN available the time of the development of the final rule. In other words, for FY 2021, eligibility for a newly merged hospital to receive interim uncompensated care payments and the amount of any interim uncompensated care payments, would be based only on the FY 2017 cost report available for the surviving CCN at the time the final rule is developed. However, at cost report settlement, we would determine the newly merged hospital's final

uncompensated care payment based on the uncompensated care costs reported on its FY 2021 cost report. That is, we would revise the numerator of Factor 3 for the newly merged hospital to reflect the uncompensated care costs reported on the newly merged hospital's FY 2021 cost report.

- *Annualization and Long Cost Reports*

We are proposing to continue the policy that was finalized in the FY 2018 IPPS/LTCH PPS final rule of annualizing uncompensated care cost data reported on the Worksheet S–10 if a hospital's cost report does not equal 12 months of data, except in the case of mergers, which would be subject to the proposed modified merger policy previously discussed. In addition, we are proposing to continue the policies that were finalized in the FY 2019 IPPS/LTCH final rule (83 FR 41415) regarding the use of the longest cost report available within the Federal fiscal year. However, we are proposing to modify our current policy for those rare situations where a hospital has a cost report that starts in one fiscal year but spans the entirety of the following fiscal year such that the hospital has no cost report starting in that subsequent fiscal year. Under this proposal, we would use the cost report that spans both fiscal years for purposes of calculating Factor 3 when data for the latter fiscal year is used in the Factor 3 methodology. The current policy for this rare situation includes the criterion that the hospital have multiple cost reports beginning in the same fiscal year. However, we no longer believe this is a necessary condition, given that we have identified some hospitals that have no FY 2017 cost report, but that only have one FY 2016 cost report, which spans the entire FY 2017 period.

- *New Hospital for Purposes of Factor 3*

We are proposing to continue the new hospital policy that was finalized in the FY 2020 IPPS/LTCH PPS final rule. Specifically, for new hospitals that do not have an FY 2017 cost

report to use in the Factor 3 calculation (that is, hospitals with CCNs established on or after October 1, 2017) that may have a preliminary projection of being eligible for DSH payments based on their most recent available disproportionate patient percentage, we are proposing that the MAC would make a final determination concerning whether the hospital is eligible to receive Medicare DSH payments at cost report settlement based on its FY 2021 cost report. If the hospital is ultimately determined to be eligible for Medicare DSH payments for FY 2021, the hospital would receive an uncompensated care payment calculated using a Factor 3, where the numerator is the uncompensated care costs reported on Worksheet S–10 of the hospital's FY 2021 cost report, and the denominator is the sum of the uncompensated care costs reported on Worksheet S–10 of the FY 2017 cost reports for all DSH-eligible hospitals. This denominator would be the same denominator that is determined prospectively for purposes of determining Factor 3 for all DSH-eligible hospitals, with the exception of Puerto Rico hospitals and IHS and Tribal hospitals. The new hospital would not receive interim uncompensated care payments before cost report settlement because we would have no FY 2017 uncompensated care data on which to determine what those interim payments should be.

- *IHS and Tribal Hospitals*

For the reasons discussed in the FY 2018 IPPS/LTCH PPS final rule (82 FR 38209), we continue to recognize that the use of data from Worksheet S–10 to calculate the uncompensated care amount for IHS and Tribal hospitals for FY 2021 may jeopardize these hospitals' payments due to their unique funding structure. Prior to this proposed rulemaking for FY 2021, CMS consulted with IHS and Tribal hospitals regarding Worksheet S-10 uncompensated care reporting as well as any potential barriers under the current cost reporting instructions to reporting by IHS and Tribal hospitals on Worksheet S-10. During the consultation,

representatives of some hospitals indicated that it was not clear to them that they could submit Worksheet S-10 data given the historical use of the low-income patient proxy when determining Factor 3 for these hospitals. CMS reiterated that the use of low-income patient proxy when determining Factor 3 does not preclude the submission of Worksheet S-10 data by these hospitals. CMS explained that IHS and Tribal Hospitals should be aware of and comply with the instructions and requirements for the submission of Worksheet S-10 data. For an overview of the instructions and requirements, one source is the MLN Matters® Special Edition article "Updates to Medicare's Cost Report Worksheet S-10 to Capture Uncompensated Care Data" that was released on September 29, 2017 and is available on the CMS website at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE17031.pdf. Another source of information is the "Worksheet S-10 - Hospital Uncompensated and Indigent Care Data Following 2018 IPPS Final Rule Questions and Answers" that is also available on the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/Worksheet-S-10-UCC-QandAs.pdf. As discussed previously in this section, CMS continues to consider the feedback provided during IHS and Tribal consultation for purposes of determining what policies should apply with respect to DSH and uncompensated care payments to IHS and Tribal hospitals in future years. We also seek comment on this issue to assist future rulemaking. We also note that the Paper Reduction Act (PRA) package for Form CMS 2552–10 will be an additional opportunity for comments on the Worksheet S-10 instructions.

Therefore, for IHS and Tribal hospitals that have a FY 2013 cost report, we are proposing to continue the policy first adopted for the FY 2018 rulemaking regarding the low-income patient

proxy. Specifically, for FY 2021 we are proposing to determine Factor 3 for these hospitals based on Medicaid days for FY 2013 and the most recent update of SSI days. The aggregate amount of uncompensated care that is used in the Factor 3 denominator for these hospitals would continue to be based on the low-income patient proxy; that is, the aggregate amount of uncompensated care determined for all DSH eligible hospitals using the low-income insured days proxy. We continue to believe this approach is appropriate because the FY 2013 data reflect the most recent available information regarding these hospitals' Medicaid days before any expansion of Medicaid. At the time of development of this proposed rule, for modeling purposes, we computed Factor 3 for these hospitals using FY 2013 Medicaid days from a HCRIS extract updated through February 19, 2020, and the most recent available FY 2018 SSI days.

- *Puerto Rico Hospitals*

With respect to Puerto Rico hospitals, we considered calculating their Factor 3 amounts for FY 2021 using the same methodology we are proposing for hospitals other than IHS and Tribal hospitals. However, we concluded that the recent natural disasters in Puerto Rico may negatively impact the ability of these hospitals to engage in the FY 2021 rulemaking on the particular issue of the data to be used to determine Factor 3 for Puerto Rico hospitals, while simultaneously focusing on ensuring that their FY 2018 uncompensated care Worksheet S-10 data is accurately reported and available for use in calculating FY 2022 Medicare uncompensated care payments consistent with our proposed approach for FY 2022 and subsequent fiscal years.

Accordingly, for FY 2021 we are proposing to determine Factor 3 for Puerto Rico hospitals that have a FY 2013 cost report based on the low-income patient proxy. We would determine Factor 3 for these hospitals based on Medicaid days for FY 2013 and the most recent

update of SSI days. The aggregate amount of uncompensated care that is used in the Factor 3 denominator for these hospitals would continue to be based on the low-income patient proxy; that is, the aggregate amount of uncompensated care determined for all DSH eligible hospitals using the low-income insured days proxy. We continue to believe the use of FY 2013 data in determining the low-income insured days proxy is appropriate because the FY 2013 data reflect the most recent available information regarding these hospitals' Medicaid days before any expansion of Medicaid. At the time of development of the proposed rule, for modeling purposes, we computed Factor 3 for these hospitals using FY 2013 Medicaid days from a recent HCRIS extract and the most recent available FY 2018 SSI days. In addition, because we are proposing to continue to use 1 year of insured low-income patient days as a proxy for uncompensated care for Puerto Rico hospitals and residents of Puerto Rico are not eligible for SSI benefits, we are proposing to continue to use a proxy for SSI days for Puerto Rico hospitals, consisting of 14 percent of a hospital's Medicaid days, as finalized in the FY 2017 IPPS/LTCH PPS final rule (81 FR 56953 through 56956).

- *All-Inclusive Rate Providers*

In FY 2018 IPPS/LTCH PPS final rule (82 FR 38218), we indicated that we would further explore which trims are appropriate to apply to the CCRs on Line 1 of Worksheet S–10, including whether it is appropriate to apply a unique trim to certain subsets of hospitals, such as all-inclusive rate providers. We noted that all-inclusive rate providers have the ability to compute and enter their appropriate CCR on Worksheet S–10, Line 1, by answering Yes to the question on Worksheet S–2, Part I, Line 115, and not have it computed using information from Worksheet C, Part I. We stated that we would give more consideration to the utilization of statewide averages in substituting outlier CCRs, and that we intended to consider other approaches that

would ensure validity of the trim methodology and not penalize hospitals that use alternative methods of cost apportionment in future rulemaking. In the FY 2020 IPPS/LTCH PPS proposed rule (84 FR 19420), we stated that we had examined the CCRs from the FY 2015 cost reports and believed the risk that all-inclusive rate providers will have aberrant CCRs and, consequently, aberrant uncompensated care data, was mitigated by the proposal to apply the trim methodology for potentially aberrant uncompensated care costs to all hospitals.

In preparation for the FY 2021 rulemaking, we conducted a review of the CCRs from the FY 2017 cost reports from all-inclusive rate providers (AIRPs) and determined that in rare situations they may include a potentially aberrant CCR (Worksheet S-10 line 1) which results in a ratio of total UCC to total operating costs of greater than 50 percent. For FY 2021, we continue to believe that all-inclusive rate providers should be excluded from the CCR trim methodology because all-inclusive rate providers have alternative methods of cost apportionment that are different from those used in the standard CCR calculation. However, in order to ensure that we are able to calculate a reasonable estimate of the hospital's FY 2017 UCC, we are proposing to modify the potentially aberrant UCC trim methodology when it is applied to all-inclusive rate providers. Specifically, we are proposing that when an AIRP's total UCC are greater than 50 percent of its total operating costs when calculated using the CCR included on its FY 2017 cost report, we would recalculate UCC using the CCR reported on Worksheet S-10, line 1 of the hospital's most recent available prior year cost report that would not result in UCC of over 50 percent of total operating costs. That is, we would apply the CCR from Worksheet S-10 line 1 of that prior cost report to the data reported on Worksheet S-10 of the FY 2017 cost report. For purposes of this proposed rule, we identified a few AIRPs that have UCC in excess of 50 percent of their total operating costs. For these hospitals, we used the CCR from Worksheet S-10, line 1

of their FY 2015 cost report in place of the CCR reported on Worksheet S-10, line 1 of their FY 2017 cost report, in order to re-calculate their UCC. We believe this approach produces a more accurate estimate of the AIRP's UCC for purposes of determining Factor 3, while continuing to reflect the information on uncompensated care included in the AIRP's FY 2017 cost report, which for the reasons discussed previously we believe is the most appropriate data to be used in determining Factor 3 for FY 2021.

- *Proposed CCR Trim Methodology*

The calculation of a hospital's total uncompensated care costs on Worksheet S-10 requires the use of the hospital's cost to charge ratio (CCR). Similar to the process used in the FY 2018 IPPS/LTCH PPS final rule (82 FR 38217 through 38218), the FY 2019 IPPS/LTCH PPS final rule (83 FR 41415 and 41416), and the FY 2020 IPPS/LTCH PPS final rule (84 FR 42372) for trimming CCRs, we are proposing the following steps to determine the applicable CCR:

Step 1: Remove Maryland hospitals. In addition, we would remove all-inclusive rate providers because their CCRs are not comparable to the CCRs calculated for other IPPS hospitals.

Step 2: For FY 2017 cost reports, calculate a CCR "ceiling" with the following data: for each IPPS hospital that was not removed in Step 1 (including non-DSH eligible hospitals), we would use cost report data to calculate a CCR by dividing the total costs on Worksheet C, Part I, Line 202, Column 3 by the charges reported on Worksheet C, Part I, Line 202, Column 8. (Combining data from multiple cost reports from the same fiscal year is not necessary, as the longer cost report would be selected.) The ceiling would be calculated as 3 standard deviations above the national geometric mean CCR for the applicable fiscal year. This approach is

consistent with the methodology for calculating the CCR ceiling used for high-cost outliers. Remove all hospitals that exceed the ceiling so that these aberrant CCRs do not skew the calculation of the statewide average CCR. (For purposes of this proposed rule, this trim would remove 12 hospitals that have a CCR above the calculated ceiling of 0.937 for FY 2017 cost reports.)

Step 3: Using the CCRs for the remaining hospitals in Step 2, determine the urban and rural statewide average CCRs for FY 2017 for hospitals within each State (including non-DSH eligible hospitals), weighted by the sum of total hospital discharges from Worksheet S–3, Part I, Line 14, Column 15. (We note that this is not a change from the methodology used in past years. In past rules, we inadvertently referred to Column 14, rather than Column 15.)

Step 4: Assign the appropriate statewide average CCR (urban or rural) calculated in Step 3 to all hospitals, excluding all-inclusive rate providers, with a CCR for FY 2017 greater than 3 standard deviations above the national geometric mean for that fiscal year (that is, the CCR "ceiling"). For this proposed rule, the statewide average CCR would apply to 12 hospitals, of which 4 hospitals have FY 2017 Worksheet S–10 data.

Step 5: For providers that did not report a CCR on Worksheet S–10, Line 1, we would assign them the statewide average CCR as determined in step 3.

After completing the above steps, we propose to re-calculate the hospital's uncompensated care costs (Line 30) using the trimmed CCR (the statewide average CCR (urban or rural, as applicable)).

- *Uncompensated Care Data Trim Methodology*

After applying the CCR trim methodology, we note that there are rare situations where a hospital has potentially aberrant data that are unrelated to CCR. Therefore, we are proposing to

continue the trim methodology for potentially aberrant UCC that was finalized in the FY 2019 and FY 2020 IPPS/LTCH PPS final rules. That is, if the hospital's uncompensated care costs for FY 2017 are an extremely high ratio (greater than 50 percent) of its total operating costs, we propose to determine the ratio of uncompensated care costs to the hospital's total operating costs from another available cost report, and to apply that ratio to the total operating expenses for the potentially aberrant fiscal year to determine an adjusted amount of uncompensated care costs. Specifically, if the FY 2017 cost report is determined to include potentially aberrant data, we are proposing that data from the FY 2018 cost report would be used for the ratio calculation. Thus, the hospital's uncompensated care costs for FY 2017 would be trimmed by multiplying its FY 2017 total operating costs by the ratio of uncompensated care costs to total operating costs from the hospital's FY 2018 cost report to calculate an estimate of the hospital's uncompensated care costs for FY 2017 for purposes of determining Factor 3 for FY 2021.

However, because we have audited the FY 2017 Worksheet S-10 data for a number of hospitals, we believe it is necessary to modify the UCC data trim methodology for hospitals whose FY 2017 cost report has been audited. Because the UCC data for these hospitals have been subject to audit, we believe there is increased confidence that if high uncompensated care costs are reported by these audited hospitals, the information is accurate. Therefore, we no longer believe it is necessary to apply the trim methodology for these audited hospitals. That is, we would exclude hospitals that were part of the audits from the trim methodology for potentially aberrant UCC. For those hospitals that do not have audited Worksheet S-10 data, we propose to continue to apply the trim methodology as previously described.

- *Summary of Proposed Methodology*

In summary, for FY 2021, we are proposing to compute Factor 3 for each hospital using the following steps—

Step 1: Select the provider's longest cost report from its Federal fiscal year (FFY) 2017 cost reports. (Alternatively, in the rare case when the provider has no FFY 2017 cost report because the cost report for the previous Federal fiscal year spanned the FFY 2017 time period, the previous Federal fiscal year cost report would be used in this step.)

Step 2: Annualize the uncompensated care costs (UCC) from Worksheet S-10 Line 30, if the cost report is more than or less than 12 months. (If applicable, use the statewide average CCR (urban or rural) to calculate uncompensated care costs.)

Step 3: Combine adjusted and/or annualized uncompensated care costs for hospitals that merged using the proposed merger policy, discussed earlier.

Step 4: Calculate Factor 3 for Indian Health Service and Tribal hospitals and Puerto Rico hospitals using the low-income insured days proxy based on FY 2013 cost report data and the most recent available SSI ratio (or, for Puerto Rico hospitals, 14 percent of the hospital's FY 2013 Medicaid days). The denominator is calculated using the low-income insured days proxy data from all DSH eligible hospitals.

Step 5: Calculate Factor 3 for the remaining DSH eligible hospitals using annualized uncompensated care costs (Worksheet S-10 Line 30) based on FY 2017 cost report data (from Step 1, 2 or 3). The hospitals for which Factor 3 was calculated in Step 4 are excluded from this calculation.

We are proposing to amend the regulation at § 412.106 by adding a new paragraph (g)(1)(iii)(C)(*7*) to reflect the proposed methodology for computing Factor 3 for FY 2021. We are also proposing to add a new paragraph (g)(1)(iii)(C)(*8*) to reflect the proposal for all

subsequent fiscal years to use the most recent available single year of audited Worksheet S-10 data to calculate Factor 3 for all eligible hospitals, except IHS and Tribal hospitals.

(e) Proposals Related to the Per Discharge Amount of Interim Uncompensated Care Payments

Consistent with the policy adopted in FY 2014 and applied in each subsequent fiscal year, we are proposing to use a 3-year average of the number of discharges for a hospital to produce an estimate of the amount of the uncompensated care payment per discharge. Specifically, the hospital's total uncompensated care payment amount, is divided by the hospital's historical 3-year average of discharges computed using the most recent available data. The result of that calculation is a per discharge payment amount that will be used to make interim uncompensated care payments to each projected DSH eligible hospital. The interim uncompensated care payments made to the hospital during the fiscal year are reconciled following the end of the year to ensure that the final payment amount is consistent with the hospital's prospectively determined uncompensated care payment for the Federal fiscal year.

In response to our proposal in the FY 2020 IPPS/LTCH PPS proposed rule to continue to determine interim uncompensated care payments using a 3-year average of discharges, we received a comment expressing concern that discharge growth discrepancies create the risk of overpayments of interim uncompensated care payments and unstable cash flows for CMS, hospitals, and MA plans (84 FR 42373). Taking the commenter's concerns into consideration, for FY 2021, we are proposing a voluntary process through which a hospital may submit a request to its Medicare Administrative Contractor (MAC) for a lower per discharge interim uncompensated care payment amount, including a reduction to zero, once before the beginning of the Federal fiscal year and/or once during the Federal fiscal year. In conjunction with this request, the hospital would be required to provide supporting documentation demonstrating there

would likely be a significant recoupment (for example, 10 percent or more of the hospital's total uncompensated care payment or at least $100,000) at cost report settlement if the per discharge amount were not lowered. For example, a hospital might submit documentation showing a large projected increase in discharges during the fiscal year to support reduction of its per discharge uncompensated care payment amount. As another example, a hospital might request that its per discharge uncompensated care payment amount be reduced to zero midyear if the hospital's interim uncompensated care payments during the year have already surpassed the total uncompensated care payment calculated for the hospital.

We are proposing that the hospital's MAC would evaluate these requests and the supporting documentation before the beginning of the Federal fiscal year and/or with midyear requests when the 3-year average of discharges is lower than hospital's projected FY 2021 discharges. If following review of the request and the supporting documentation, the MAC agrees that there likely would be significant recoupment of the hospital's interim Medicare uncompensated care payments at cost report settlement, the only change that would be made would be to lower the per discharge amount either to the amount requested by the hospital or another amount determined by the MAC to be appropriate to reduce the likelihood of a substantial recoupment at cost report settlement. No change would be made to the total uncompensated care payment amount determined for the hospital on the basis of its Factor 3. In other words, this proposal does not change how the total uncompensated care payment amount will be reconciled at cost report settlement.

(f) Process for Notifying CMS of Merger Updates and to Report Upload Issues

As we have done for every proposed and final rule beginning in FY 2014, in conjunction with both the FY 2021 IPPS/LTCH PPS proposed rule and final rule, we will publish on the

CMS website a table listing Factor 3 for all hospitals that we estimate would receive empirically justified Medicare DSH payments in FY 2021 (that is, those hospitals that 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 Medicare DSH payment in the event that they receive an empirically justified Medicare DSH payment for the fiscal year as determined at cost report settlement. We note that, at the time of development of the proposed rule, the FY 2018 SSI ratios were available. Accordingly, for purposes of the proposed rule, we computed Factor 3 for Indian Health Service and Tribal hospitals and Puerto Rico hospitals using the most recent available data regarding SSI days from the FY 2018 SSI ratios.

We also will publish a supplemental data file containing 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 this FY 2021 IPPS/LTCH PPS proposed rule to review the table and supplemental data file published on the CMS website in conjunction with this proposed rule and to notify CMS in writing of issues related to mergers and/or to report potential upload discrepancies due to MAC mishandling of the Worksheet S-10 data during the report submission process (for example, report not reflecting audit results due to MAC mishandling or most recent report differs from previously accepted amended report due to MAC mishandling). Comments raising issues that are specific to the information included in the table and supplemental data file can be submitted to the CMS DSH inbox at Section3133DSH@cms.hhs.gov. All other comments submitted in response to our proposed policies for determining uncompensated care payments for FY 2021 must be submitted in one of three ways found in the **ADDRESSES** section of this proposed rule before the close of the

comment period in order to be assured consideration. In addition, this CMS DSH inbox is not intended for Worksheet S-10 audit process related emails, which should be directed to the MACs. We will address comments related to mergers and/or reporting upload discrepancies submitted to the CMS DSH inbox as appropriate in the table and the supplemental data file that we publish on the CMS website in conjunction with the publication of the FY 2021 IPPS/LTCH PPS final rule.

For FY 2021, we are proposing that after the publication of the FY 2021 IPPS/LTCH PPS final rule, hospitals would have 15 business days from the date of public display of the FY 2021 IPPS/LTCH PPS final rule to review and submit comments on the accuracy of the table and supplemental data file published in conjunction with the final rule. Any changes to Factor 3 will be posted on the CMS website prior to October 1, 2020. We acknowledge that this is less time compared to previous years. However, there is only a limited amount of time to review the information submitted by the hospitals and to implement the finalized policies before the start of the Federal fiscal year. In general, we believe hospitals will have sufficient opportunity during the proposed rule's comment period to provide information about recent and/or pending mergers and/or to report upload discrepancies. We currently expect to use data from the March 2020 HCRIS extract for the FY 2021 final rule, which contributes to our increased confidence that hospitals will be able to comment on mergers and report any upload discrepancies during the comment period for this proposed rule. As noted earlier in this section, for purposes of calculating final Factor 3 in the FY 2021 IPPS/LTCH PPS final rule, we may also consider using more recent data that may become available after March 2020, but before the final rule. In the event that there are any remaining merger updates and/or upload discrepancies after the final rule, the 15 business days from the date of public display of the FY 2021 IPPS/LTCH PPS final

rule deadline should allow for the time necessary to prepare and make any corrections to Factor 3 calculations before the beginning of the Federal fiscal year. In addition, we intend to revisit in future rulemaking whether to discontinue this additional comment process after the final rule, because we believe, in general, the comment period on the proposed rule should provide sufficient opportunity for hospitals to notify CMS regarding pending mergers and/or to report upload discrepancies.

We are inviting public comments on our proposed methodology for calculating Factor 3 for FY 2021, including, but not limited to, our proposed use of FY 2017 Worksheet S–10 data. In addition, we also request public comments on our proposal to calculate Factor 3 for all subsequent fiscal years and for all eligible hospitals, except Indian Health Service and Tribal hospitals, using the most recent available single year of audited Worksheet S-10 data.
We are also seeking comments on the potential use of our exceptions and adjustments authority under section 1886(d)(5)(I)(i) of the Act to restructure the DSH and uncompensated care payments to IHS and Tribal hospitals for FY 2022 and subsequent fiscal years, as described earlier.

H. Proposed Payment for Allogeneic Hematopoietic Stem Cell Acquisition Costs (§ 412.113)

1. Background

Medicare reimburses allogeneic hematopoietic stem cell transplants provided to Medicare beneficiaries for the treatment of certain diagnoses if such treatment is considered reasonable and necessary. Allogeneic hematopoietic stem cell transplants involve collecting or acquiring stem cells from a healthy donor's bone marrow, peripheral blood, or cord blood for intravenous infusion to the recipient. Currently, acquisition costs associated with allogeneic hematopoietic stem cell transplants are included in the operating costs of inpatient hospital services for