

is incompatible with the selected category of hazardous material. For example, the Postal Service may be able to warn (or lock out) a mailer during the postage payment process, when the mailer attempts to combine an air-eligible product (e.g., First-Class Package Service or Priority Mail) with a category of hazardous material restricted to ground transportation only (e.g. limited quantity ground material or flammable solid). If this proposal is adopted, the Postal Service plans to review its systems to determine if such an enhancement is possible and practical.

Enforcement

If this proposal is adopted, the United States Postal Inspection Service® (USPIS®) expects universal compliance by mailers following a reasonable period of time to communicate the new requirements to mailers and postage payment providers, and for them to make the necessary changes to their systems. Following the implementation period, the USPIS intends to enforce these new requirements using its civil penalty authority under 39 U.S.C. 3018.

Brittany Johnson,

Attorney, Federal Compliance.

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BILLING CODE P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 412

[CMS-1739-P]

RIN 0938-AU24

Medicare Program; Treatment of Medicare Part C Days in the Calculation of a Hospital's Medicare Disproportionate Patient Percentage

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

ACTION: Proposed rule.

SUMMARY: This proposed rule would establish a policy concerning the treatment of patient days associated with persons enrolled in a Medicare Part C (also known as “Medicare Advantage”) plan for purposes of calculating a hospital's disproportionate patient percentage for cost reporting periods starting before fiscal year (FY) 2014 in response to the ruling in *Azar v. Allina Health Services*, 139 S. Ct. 1804 (June 3, 2019).

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on EDT on October 5, 2020.

ADDRESSES: In commenting, please refer to file code CMS-1739-P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

Comments, including mass comment submissions, must be submitted in one of the following three ways (please choose only one of the ways listed):

1. *Electronically.* You may submit electronic comments on this regulation to <http://www.regulations.gov>. Follow the “Submit a comment” instructions.

2. *By regular mail.* You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-1739-P, P.O. Box 8013, Baltimore, MD 21244-8013.

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

3. *By express or overnight mail.* You may send written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-1739-P, Mail Stop C4-26-05, 7500 Security Boulevard, Baltimore, MD 21244-1850.

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

FOR FURTHER INFORMATION CONTACT:

Donald Thompson (410) 786-4487.

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

I. Executive Summary and Background

A. Purpose and Legal Authority

This proposed rule would create a policy governing the treatment of days associated with beneficiaries enrolled in Medicare Part C for discharges occurring prior to October 1, 2013, for the purposes of determining the additional Medicare payments to subsection (d) hospitals under section 1886(d)(5)(F) of the Social Security Act (the Act).

B. Summary of Major Provisions

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) payment 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 more 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 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 inpatient prospective payment system (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.

C. Summary of Costs and Benefits

If we adopted our proposal to include days associated with patients enrolled

in Medicare Part C in the calculation of the SSI ratio and to exclude them from the calculation of the numerator of the Medicaid fraction, there would not be any additional costs or benefits relative to the Medicare DSH payments that have already been made because those payments were made under the policy reflected in the proposal (prior to it having been vacated). The effect of this proposed rule would be to avoid the consequences of legal ambiguity that would otherwise continue into the future; the resulting costs, benefits and transfer impacts are thus highly uncertain.

In order to quantify one point in the relevant uncertainty range, we considered excluding days associated with patients enrolled in Medicare Part C from the calculation of the SSI ratio and (for patients also eligible for Medicaid) including them in the calculation of the numerator of the Medicaid fraction. We refer readers to section V.D. of this proposed rule for a discussion of this alternative considered.

II. Provisions of the Proposed Regulations—Treatment of Patient Days Associated With Patients Enrolled in Medicare Advantage Plans With Discharge Dates Before October 1, 2013, in the Medicare and Medicaid Fractions of the Disproportionate Patient Percentage (DPP)

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

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

In 2012, a district court vacated the final policy adopted in the FY 2005 final rule on the basis that the final rule was not a “logical outgrowth” of the proposed rule. In the FY 2014 IPPS/LTCH PPS proposed rule, we proposed

to re-adopt the policy of including MA patient days in the Medicare fraction prospectively for FY 2014 and subsequent fiscal years (78 FR 27578). We finalized this proposal in the FY 2014 IPPS/LTCH PPS final rule (78 FR 50614). We made no change to the regulation text at § 412.106(b)(2)(i) because the text of the regulation already reflected the policy we adopted in the FY 2014 IPPS/LTCH PPS final rule. In 2014, the United States Court of Appeals for the D.C. Circuit upheld the district court’s holding that the policy adopted in the FY 2005 IPPS final rule requiring inclusion of Part C days in the Medicare fraction was not a logical outgrowth of the proposed rule, but left open the possibility that we could employ the same approach through adjudication.

In *Azar v. Allina Health Services*, 139 S. Ct. 1804 (June 3, 2019), the Supreme Court considered a challenge to the agency’s inclusion of MA patient days in the Medicare fractions it published for FY 2012. Section 1871(a)(2) of the Act requires notice-and-comment rulemaking for any Medicare “rule, requirement, or other statement of policy” that “establishes or changes a substantive legal standard governing the scope of benefits, the payment for services, or the eligibility of individuals, entities, or organizations to furnish or receive services or benefits.” The Supreme Court held that section 1871(a)(2) of the Act required CMS to engage in notice-and-comment rulemaking before adopting its policy regarding treatment of inpatient days for beneficiaries enrolled in MA plans for purposes of calculating the DPP.

Section 1871(e)(1)(A) of the Act authorizes CMS to engage in retroactive rulemaking when the Secretary determines that such retroactive application is necessary to comply with statutory requirements or that a failure to apply a policy retroactively would be contrary to the public interest. For example, CMS has invoked its authority to engage in retroactive rulemaking under section 1871(e)(1)(A) of the Act in connection with its policy related to bad debt (see the FY 2021 IPPS/LTCH PPS proposed rule (85 FR 32867)), predicate facts and cost report reopening (see the CY 2014 OPPS final rule (78 FR 75165)), and the low-volume hospital adjustment (see the FY 2020 IPPS/LTCH PPS final rule (84 FR 42349)).

Section 1886(d)(5)(F) of the Act requires CMS to make DSH payments to eligible hospitals. Calculating such payments, in turn, requires CMS to calculate a Medicare and a Medicaid fraction for each hospital. Under section 1886(d)(5)(F)(vi)(I) of the Act, the

Medicare fraction must include the patient days for beneficiaries “entitled to benefits under part A.” The Court of Appeals for the D.C. Circuit has held that the Medicare statute does not speak directly to how Part C days should be treated for purposes of DSH calculations, that is, whether Part C patients are “entitled to benefits under part A” and should therefore be included in the Medicare fraction, or whether they are not so entitled, and should therefore be included in the numerator of the Medicaid fraction if they are also eligible for Medicaid. (See *Ne. Hosp. Corp. v. Sebelius*, 657 F.3d 1, 13 (D.C. Cir. 2011).) However, the court has also found that section 1886(d)(5)(F)(vi) of the Act requires the Secretary to account for Part C days in the DPP calculation by including them in one of the fractions (Medicare or Medicaid) and excluding them from the other. (See *Allina Health Servs. v. Sebelius*, 746 F.3d 1102, 1108 (D.C. Cir. 2014).)

Because the FY 2005 IPPS final rule was vacated, the Secretary “has no promulgated rule governing” the treatment of Part C days for fiscal years before 2014.” (See *Allina Health Servs. v. Price*, 863 F.3d 937, 939 (D.C. Cir. 2017).) As a result, in order to comply with the statutory requirement to calculate Medicare DSH payments, CMS must determine whether beneficiaries enrolled in Part C are “entitled to benefits under part A” and so must be included in the Medicare fraction (and excluded from the numerator of the Medicaid fraction), or are not so entitled and so must be excluded from the Medicare fraction (and included in the numerator of the Medicaid fraction, if dually eligible). The Secretary has therefore determined that, in order to comply with the statutory requirement to make DSH payments, it is necessary for CMS to engage in retroactive rulemaking to establish a policy to govern whether individuals enrolled in MA plans under Part C should be included in the Medicare fraction or in the numerator of the Medicaid fraction, if dually eligible, for fiscal years before 2014.

We continue to believe, as we stated in the preamble to the FY 2014 IPPS/LTCH PPS final rule (78 FR 50614 and 50615) and have consistently expressed since the issuance of the FY 2005 IPPS final rule, that individuals enrolled in MA plans are “entitled to benefits under part A” as the phrase is used in the DSH provisions at section 1886(d)(5)(F)(vi) of the Act. Section 226(a) of the Act provides that an individual is automatically “entitled” to Medicare Part A when the person reaches age 65

or becomes disabled, provided that the individual is entitled to Social Security benefits under section 202 of the Act. Beneficiaries who are enrolled in MA plans provided under Medicare Part C continue to meet all of the statutory criteria for entitlement to Medicare Part A benefits under section 226 of the Act. Moreover, section 1852(a)(1)(B)(i) of the Act provides that in order to enroll in Medicare Part C, or to change from one MA plan to another MA plan offered under Part C, a beneficiary must be “entitled to benefits under Part A and enrolled under Part B.” Thus, by definition, a beneficiary must be entitled to Part A to be enrolled in Part C. There is nothing in the Act that suggests that beneficiaries who enroll in a Medicare Part C plan thereby forfeit their entitlement to Medicare Part A benefits. To the contrary, enrollment in a plan under Medicare Part C is simply an option that a person entitled to Part A benefits may choose as a way to receive their Part A benefits. A beneficiary who enrolls in Medicare Part C is entitled to receive benefits under Medicare Part A through the MA plan in which he or she is enrolled, and the MA organization’s costs in providing such Part A benefits are paid for by CMS with money from the Medicare Part A Trust Fund. In addition, under certain circumstances, Medicare Part A pays directly for care furnished to patients enrolled in Medicare Part C plans, rather than indirectly through Medicare Part A Trust Fund payments to MA organizations. For example, under section 1852(a)(5) of the Act, if, during the course of the year, the scope of benefits provided under Medicare Part A expands beyond a certain cost threshold due to Congressional action or a national coverage determination, Medicare Part A will pay providers directly for the cost of those services provided to beneficiaries enrolled in Part C. Similarly, Medicare Part A pays directly for hospice care furnished to MA patients who elect under section 1812(d)(1) of the Act to receive such care from a particular hospice program and, under certain circumstances, for federally qualified health center (FQHC) services provided to MA patients by FQHCs that contract with MA organizations under sections 1853(h)(2) and 1853(a)(4) of the Act, respectively. Thus, we continue to believe that a patient enrolled in an MA plan remains entitled to benefits under Medicare Part A, and should be counted in the Medicare fraction of the DPP, and not the numerator of the Medicaid fraction.

Additionally, the Secretary has determined that it is in the public interest for CMS to adopt a policy for the treatment of MA patient days in the Medicare and Medicaid fractions through notice and comment rulemaking retroactively for discharges before October 1, 2013 (the effective date of the FY 2014 IPPS/LTCH PPS final rule). CMS must calculate DSH payments for periods that include discharges occurring before the effective date of the FY 2014 prospective rule for hundreds of hospitals whose DSH payments for those periods are still open or have not yet been finally settled, encompassing thousands of cost reports. In order to calculate these payments, CMS must establish Medicare fractions for each applicable cost reporting period during the time period for which there is currently no regulation in place that expressly addresses the treatment of Part C days. Because the Supreme Court has held that CMS cannot resolve this issue except by notice-and-comment rulemaking, we have concluded that the only way for CMS to resolve this issue and properly calculate DSH payments for time periods before FY 2014 is to establish a new regulation that would apply retroactively to the determination of Medicare and Medicaid fractions for this time period. Consequently, retroactive rulemaking is not only necessary to comply with statutory requirements, but is also necessary to avoid an outcome that would be contrary to the public interest. Absent such a retroactive rule, the Secretary would be unable to calculate and confirm proper DSH payments for time periods before FY 2014, which would be contrary to the public interest of providing additional payments to hospitals that serve a significantly disproportionate number of low-income patients, as expressed in the DSH provisions of the Medicare statute. Moreover, to the extent the Secretary must adopt an approach to calculate those payments, it is in the public interest to permit interested stakeholders to comment on the proposed approach and for the agency to have the benefit of those comments in the development of any final rule. Therefore, for the purposes of calculating the Medicare and Medicaid fractions for cost reporting periods that include discharges before October 1, 2013, we are proposing to adopt the same policy of including MA patient days in the Medicare fraction that was prospectively adopted in the FY 2014 IPPS/LTCH PPS final rule and to apply this policy retroactively to any cost

reports that remain open for cost reporting periods starting before October 1, 2013. We do not expect this proposal to have an effect on payments as the payments previously made reflect the proposed policy. We are not proposing any change to the regulation text because the current text at § 412.106(b)(2)(i) reflects the policy being proposed for fiscal years before FY 2014.

Because we are proposing to establish this policy retroactively, it would cover cost reporting periods for which many cost reports have already been final settled. Consistent with § 405.1885(c)(2), any final rule retroactively adopting the policy at § 412.106(b)(2)(i) for fiscal years before FY 2014 would not be a basis for reopening these final settled cost reports.

We seek comments on our proposal to include MA patient days in the Medicare fraction for fiscal years before FY 2014, and also on the alternative, which is discussed in detail in section V. of this proposed rule, of including MA patient days for dually eligible beneficiaries in the numerator of the Medicaid fraction for those fiscal years.

III. Collection of Information Requirements

This document does not impose information collection requirements, that is, reporting, recordkeeping, or third-party disclosure requirements. Consequently, there is no need for review by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*).

IV. Response to Comments

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

V. Regulatory Impact Analysis

A. Statement of Need

This proposal is necessary to create a policy governing the treatment of days associated with beneficiaries enrolled in Medicare Part C for discharges occurring prior to October 1, 2013, for the purposes of determining additional Medicare payments to subsection (d) hospitals under section 1886(d)(5)(F) of the Act.

B. Overall Impact

We have examined the impact of this rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), the Regulatory Flexibility Act (RFA) (5 U.S.C. 603), section 1102(b) of the Act, section 202 of the Unfunded Mandates Reform Act of 1995 (2 U.S.C. 1532), Executive Order 13132 on Federalism (August 4, 1999), the Congressional Review Act (5 U.S.C. 804(2)), and Executive Order 13771 on Reducing Regulation and Controlling Regulatory Costs (January 30, 2017).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). Section 3(f) of Executive Order 12866 defines a “significant regulatory action” as an action that is likely to result in a rule: (1) Having an annual effect on the economy of \$100 million or more in any 1 year, or adversely and materially affecting a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local or tribal governments or communities (also referred to as “economically significant”); (2) creating a serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impact of entitlements, grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raising novel legal or policy issues arising out of legal mandates, the President’s priorities, or the principles set forth in Executive Order 12866.

The discussion accompanying our proposal along with this Regulatory Impact Analysis (RIA) demonstrate that this proposed rule has been analyzed consistent with the regulatory philosophy and principles identified in Executive Orders 12866 and 13563, the RFA, and section 1102(b) of the Act. We note that Medicare DSH payments affect a substantial number of small rural hospitals, as well as other classes of hospitals, and the effect of Medicare DSH payments on some hospitals is significant.

An RIA must be prepared for major rules with economically significant effects (\$100 million or more in any 1 year). This rulemaking is “economically

significant” as measured by the \$100 million threshold, and hence also a major rule under the Congressional Review Act, 5 U.S.C. 804(2). Accordingly, we have prepared an RIA that to the best of our ability presents the costs and benefits of the rulemaking.

C. Detailed Economic Analysis

Medicare DSH payments have already been made under the policy reflected in the proposal (prior to the policy having been vacated by the Court of Appeals, which was affirmed by the Supreme Court’s decision). Therefore, the effect of this proposed rule would be to avoid the consequences of legal ambiguity that would otherwise continue into the future; the resulting costs, benefits and transfer impacts are thus highly uncertain. In other words, given that there is currently no regulation governing the treatment of Part C days, it is not clear what to compare an estimate of DSH payments under our proposed policy to in order to determine the effect of our proposed policy on DSH payments. There are multiple possible trajectories whereby agency actions could be made consistent with the Supreme Court’s ruling requiring notice-and-comment rulemaking. Our proposed policy is one such trajectory and DSH payments made under our proposed policy would not differ from hospitals’ historical DSH payments. This comparison between DSH payments under our proposed policy and hospitals’ historical DSH payments quantifies one point within the relevant uncertainty range of potential costs, benefits, and transfer impacts. However, in order to explore another possible trajectory (and thus to quantify an additional point within the relevant uncertainty range), we considered an approach of excluding days associated with patients enrolled in Medicare Part C from the calculation of the SSI ratio and including them in the numerator of the Medicaid fraction (for those patients who are dually eligible). We are not proposing such a policy because we continue to believe, as we stated in the preamble to the FY 2014 IPPS/LTCH PPS final rule (78 FR 50614 and 50615) and have consistently expressed since the issuance of the FY 2005 IPPS final rule, that individuals enrolled in MA plans are “entitled to benefits under part A” as the phrase is used in the DSH provisions at section 1886(d)(5)(F)(vi) of the Act.

We created a public use data file in order to facilitate public comment and analysis of our proposal and the alternative approach. This file is available in the Downloads section of the Disproportionate Share Hospital

web page on the CMS website: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh>. The file contains an illustrative model at the hospital level of the potential effect on the DSH adjustment of excluding days associated with patients enrolled in Medicare Part C from the SSI ratio and including them in the numerator of the Medicaid fraction (for those patients who are dually eligible).

In constructing the model, we used data from hospital cost reports for hospitals that were eligible for and received Medicare DSH payments for their longest cost reporting period ending between January 1, 2013, and December 31, 2013, inclusive of those dates, as reflected in the Healthcare Cost Report Information System (HCRIS) data. (For more information on the HCRIS data, see <https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Cost-Reports/Hospital-2010-form>.) We chose this time period to model because these cost reports generally contain the bulk of the most recent cost report data for hospitals prior to our readopting the policy of including MA patient days in the Medicare fraction in the FY 2014 IPPS/LTCH PPS final rule. We also incorporated relevant data from the MedPAR data files and the SSI eligibility files pertaining to that time period. These are the same source files used to construct the FY SSI Ratio files also found in the Downloads section of the Disproportionate Share Hospital web page on the CMS website.

In order to model the Medicare fraction for each hospital, we estimated the SSI ratio applicable to that hospital's cost report after excluding days associated with patients enrolled in Medicare Part C.

In order to model the Medicaid fraction for each hospital, we used the days associated with patients enrolled in Medicare Part C who were also eligible for SSI, based on the applicable SSI eligibility data, as a proxy for the Medicaid days associated with patients enrolled in Medicare Part C. We used this proxy, because we do not have readily available specific data on Medicaid eligibility for beneficiaries who are eligible for SSI benefits. However, we believe this proxy is reasonable because the majority of states provide Medicaid eligibility to people eligible for SSI benefits. The Part C SSI days for each hospital were then added to the numerator of the otherwise applicable Medicaid fraction for that hospital as reflected in the hospital's cost report data.

We then used these alternative Medicare and Medicaid fractions to model the percent change in the Medicare DSH adjustment for the hospital.

The modelled percent change in the Medicare DSH adjustment was applied to an annualized Medicare DSH payment from the hospital's cost report to estimate the 12-month change in Medicare DSH payments to that hospital.

Based on this model, most hospitals' Medicare DSH payments would increase relative to their historical Medicare DSH payments; however, some hospitals' Medicare DSH payments would decrease or not change. In aggregate, the modelled Medicare DSH payments would increase by 6 percent relative to the historical Medicare DSH payments, which for the hospitals represented in the model was approximately a net \$0.6 billion annualized increase for this time period.

We note that these estimates are for illustrative purposes and involve modelling assumptions (for example, use of a proxy for the Medicaid days associated with patients enrolled in Medicare Part C, as described previously), which may differ from actual calculations that would be done during cost report review and settlement processes by contractors if such a policy were adopted. These expenditures (or, as regards payments already made for past years, the avoidance of potentially necessary reimbursements from providers to the Trust Fund) would be classified as transfers to Medicare providers.

We are seeking comments on this illustrative model and the assumptions used in this analysis.

D. Alternative Considered

We considered as an alternative to our proposal excluding days associated with patients enrolled in Medicare Part C from the calculation of the SSI ratio and including them in the calculation of the Medicaid fraction. However, we are not proposing such a policy because we continue to believe, as we stated in the preamble to the FY 2014 IPPS/LTCH PPS final rule (78 FR 50614 and 50615) and have consistently expressed since the issuance of the FY 2005 IPPS final rule, that individuals enrolled in MA plans are "entitled to benefits under part A" as the phrase is used in the DSH provisions at section 1886(d)(5)(F)(vi) of the Act.

Similar to the discussion in section V.C. of this proposed rule regarding DSH payments under our proposed policy, because it is not clear what DSH payments prior to FY 2014 would be

given that there is currently no regulation governing the treatment of Part C days, it is not clear what to compare an estimate of DSH payments under the alternative to in order to determine the change in DSH payments. Taking the quantitative impact estimate that appears earlier that DSH payments made under the alternative policy would represent an increase of \$0.6 billion over hospitals' historical DSH payments for the relevant time period—that is, projecting a transfer of the same \$0.6 billion magnitude—yields an estimate of the alternative's impact relative to hospitals' historical DSH payments. As in the analysis of the policy as proposed, the alternative's impact estimate represents a boundary on an especially wide uncertainty range.

E. Accounting Statement

As required by OMB Circular A-4, in the following Table 1, we have prepared an accounting statement showing the classification of the expenditures associated with the provisions of this proposed rule as they relate to hospitals receiving Medicare DSH payments. This table provides our best estimate of the change in Medicare DSH payments to hospitals as a result of our proposal. All expenditures are classified as transfers to Medicare providers.

TABLE 1—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED MEDICARE DSH EXPENDITURES PRIOR TO FY 2014

Category	Transfers
Annualized Monetized Transfers. From Whom to Whom	\$0 to \$0.6 billion. Federal Government to Hospitals Receiving Medicare DSH Payments.

F. Regulatory Flexibility Act (RFA)

The RFA requires agencies to analyze options for regulatory relief of small entities, if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of less than \$7.5 million to \$38.5 million in any 1 year. Individuals and states are not included in the definition of a small entity. We are not preparing an analysis for the RFA because we have determined, and the Secretary certifies, that if we adopted our proposal there would not be any additional costs or

benefits relative to Medicare DSH payments that have already been made. Therefore, this proposed rule will not have a significant economic impact on a substantial number of small entities.

In addition, section 1102(b) of the Act requires us to prepare an RIA if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 100 beds. We are not preparing an analysis for section 1102(b) of the Act because we have determined, and the Secretary certifies, that if we adopted our proposal there would not be any additional costs or benefits for small rural hospitals relative to Medicare DSH payments that have already been made to these hospitals. Therefore, this proposed rule would not have a significant impact on the operations of a substantial number of small rural hospitals.

G. Unfunded Mandates Reform Act (UMRA)

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated

costs and benefits before issuing any rule whose mandates require spending in any 1 year of \$100 million in 1995 dollars, updated annually for inflation. In 2020, that threshold is approximately \$156 million. This proposed rule will have no consequential effect on state, local, or tribal governments or on the private sector.

H. Federalism

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

I. Regulatory Reform Analysis Under Executive Order 13771

Executive Order 13771, titled Reducing Regulation and Controlling Regulatory Costs, was issued on January 30, 2017, and requires that the costs associated with significant new regulations “shall, to the extent permitted by law, be offset by the elimination of existing costs associated

with at least two prior regulations.” OMB’s *Guidance Implementing Executive Order 13771, Titled “Reducing Regulation and Controlling Regulatory Costs”*, issued on April 5, 2017, available at <https://www.whitehouse.gov/sites/whitehouse.gov/files/omb/memoranda/2017/M-17-21-OMB.pdf>, explains that “E.O. 13771 deregulatory actions are not limited to those defined as significant under E.O. 12866 or OMB’s *Final Bulletin on Good Guidance Practices*.” It has been determined that this proposed rule imposes no more than de minimis costs, and therefore is not considered a regulatory action under Executive Order 13771.

In accordance with the provisions of Executive Order 12866, this proposed rule was reviewed by the Office of Management and Budget.

Dated: March 24, 2020.

Seema Verma,

Administrator, Centers for Medicare & Medicaid Services.

Dated: April 09, 2020.

Alex M. Azar II,

Secretary, Department of Health and Human Services.

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