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.

We did not receive any comments regarding the IME adjustment factor, which, as noted earlier, is statutorily required. Accordingly, for discharges occurring during FY 2021, the IME formula multiplier is 1.35.

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 final 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 statutory adjustment of 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 final 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 payment methodology at section 1886(r) (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 final rule, there are 22 hospitals that will be participating in the demonstration program in FY 2021. 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.

Comment: A commenter stated that their hospital has recently submitted its fiscal year end 12/31/2019 cost report and that due to the Medicaid Expansion in their respective state, the hospital believed it would qualify for DSH and uncompensated care payments in FY 2021 based on the information reflected in this submission. However, the commenter noted that the FY 2021 NPRM DSH Public Use File lists the hospital as a "No" in the column for projected DSH eligibility because the data used in the proposed rule was based on a cost report year pre-Medicaid expansion. The commenter asks CMS to consider updating their hospital's DSH eligibility status and using its recently submitted as-filed cost report in the final rule's FY 2021 DSH PUF File for purposes of projected DSH eligibility.

Response: The regulation located at 42 CFR 412.106 governs eligibility for the Medicare DSH payment adjustment and specifies how the disproportionate patient percentage is calculated. The DSH public use file does not determine DSH eligibility. A hospital's eligibility to receive empirically justified DSH payments, can change throughout the year as the MACs receive and review updated data.

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 final rule, we discuss the data sources and methodologies for computing each of these factors, our final policies for FYs 2014 through 2020, and the policies we are finalizing for FY 2021.

a. 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 final rule, in order to determine Factor 1 in the uncompensated care payment formula for FY 2021, we proposed to continue the policy established in the FY 2014 IPPS/LTCH PPS final rule (78 FR 50628 through 50630) and in the FY 2014 IPPS interim final rule with comment period (78 FR 61194) 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 this FY 2021 IPPS/LTCH PPS final rule.

Therefore, in order to determine the two elements of 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 final 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 our proposal for Factor 1 and modeling the impact of the 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 were then 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 the 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, was 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, was approximately $3.840 billion (or 25 percent of the total amount of estimated Medicare DSH payments for FY 2021). Under § 412.106(g)(1)(i) of the regulations, Factor 1 is the difference between these two estimates of the Office of the Actuary. Therefore, in the proposed rule, we proposed that Factor 1 for FY 2021 would be $ 11,518,901,035.84, which was 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). In the FY 20201 IPPS/LTCH PPS proposed rule (85 FR 32748), we noted that consistent with our approach in previous rulemakings, OACT intended 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.

We noted in the FY 2021 IPPS/LTCH PPS proposed rule, that the Factor 1 estimates for final 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 OMB website at: https://www.whitehouse.gov/omb/budget. We recognized 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 indicated that we believe commenters are able to meaningfully comment on our 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 referred 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 noted 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.

In the FY 2021 IPPS/LTCH PPS proposed rule, we referred 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).

Comment: As in previous years, a common concern and/or request expressed by some commenters was the need for greater transparency in the methodology used by CMS and OACT

to calculate Factor 1; several commenters specifically requested that a detailed description of the methodology be made public. In relation to this, a commenter asserted that the lack of opportunity afforded to hospitals to review the data used in rulemaking is in violation of the Administrative Procedure Act and expressed concerns about the lack of transparency in how Factor 1 is calculated, arguing that hospitals cannot meaningfully comment on the methodology given the lack of details. In particular, this commenter asserted that the proposed rule neither explained the assumption that Medicaid expansion would draw enrollees who are healthier than the average Medicaid beneficiary and, by extension, would have fewer hospital visits, nor described the data CMS used in making this assumption.

Response: We thank the commenters for their input. We disagree with commenters' assertion regarding the lack of transparency with respect to the methodology and assumptions used in the calculation of Factor 1. As explained in the FY 2021 IPPS/LTCH PPS proposed rule, and in this section of this final rule, we have been and continue to be transparent about the methodology and data used to estimate Factor 1. Regarding the commenters who reference the Administrative Procedure Act, we note that under the Administrative Procedure Act, a proposed rule is required to include either the terms or substance of the proposed rule or a description of the subjects and issues involved. In this case, the FY 2021 IPPS/LTCH PPS proposed rule did include a detailed discussion of our proposed Factor 1 methodology and the data sources that would be used in making our final estimate.

To provide context, we note that Factor 1 is not estimated in isolation from other projections made by OACT. 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 in this final rule are generally consistent

with those used for the "2020 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 under "Downloads." For additional information on the development of the President's Budget, we refer readers to the OMB 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 and the Medicare Trustees Report 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 budget.

For a general overview of the principal steps involved in projecting future inpatient costs and utilization, we refer readers to the 2020 Medicare Trustees Report. 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 2018 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/MedicaidReport2018.pdf for a discussion of

general issues regarding Medicaid projections. Additionally, as described in more detail later in this section, in the FY 2021 IPPS/LTCH PPS proposed rule, we included information regarding the data sources, methods, and assumptions employed by the actuaries in determining the OACT's estimate of Factor 1. In summary, we indicated the historical HCRIS data update OACT used to identify Medicare DSH payments, we explained that the most recent Medicare DSH payment adjustments provided in the IPPS Impact File were used, and we provided the components of all 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 included a description of the "Other" and "Discharges" assumptions, as well as additional information regarding how we address the Medicaid and CHIP expansion.

Regarding the commenters' requests for further information on our assumptions regarding Medicaid expansion on the Medicaid population, we provide a discussion of more recent estimates and assumptions regarding Medicaid expansion as part of the discussion of the final Factor 1 for FY 2021, which also incorporates the estimated impact of the COVID-19 pandemic.

Comment: The majority of comments on Factor 1 raised concerns regarding the adverse economic effects resulting from the COVID-19 Public Health Emergency (PHE) and the impact on the estimate of Factor 1. A common concern raised by commenters was the discrepancy between the current macroeconomic conditions and the actual inputs used to estimate Factor 1 in the FY 2021 IPPS/LTCH PPS proposed rule. A commenter pointed out that the Factor 1 estimate used in the FY 2021 Final Rule would normally be generally consistent with the assumptions and projections in the Midsession Review of the President's Budget; however, the commenter noted

that the Midsession Review for FY 2021 did not report updated economic assumptions and hence would not account for the impact that the COVID-19 PHE has had and will continue to have on empirically justified DSH payments. This commenter stated that even in the absence of updated Midsession Review projections, OACT remains obligated to account for COVID-19 in projecting the amount of empirically justified Medicare DSH payments by using the latest economic forecasts from reliable sources. As in years past, this commenter, as well as many others, also emphasized the importance of the "Other" factor used in the calculation of Factor 1 and highlighted the impact that the increase in Medicaid enrollment associated with the adverse economic effects of the COVID-19 PHE would have on this factor. A handful of commenters also requested that CMS clarify why the "Other" factor, as well as the case-mix and discharge factors, have decreased as compared to previous years. A commenter believed that there would be increasing Medicaid utilization due to the pandemic and referred to the funding for COVID-19 testing and treatment for uninsured individuals made available under the Families First Coronavirus Response Act and CARES Act. This same commenter also believed staggering levels of unemployment would contribute to increased Medicaid utilization until the pandemic passes and the economy stabilizes.

Commenters highlighted the proposed decrease in Factor 1 of $919 million from FY 2020 to FY 2021 and cited several data sources that they believe would indicate that such a decrease in estimated DSH payments would be inconsistent with the current economic situation. For example, several commenters pointed out that, according to the Congressional Budget Office (CBO), the unemployment rate is projected to be 9.5 percent by the end of FY 2021, which in turn would indicate an increase in Medicaid enrollment. Many commenters also cited estimates by the Urban Institute, which estimated that 12 to 21 million people would become eligible for

Medicaid as a result of losing Employer-Sponsored Insurance (ESI) due to the COVID-19 PHE. Commenters also referenced a Kaiser Family Foundation estimate that 27 million would lose ESI as of May 2, 2020, with nearly half being eligible for Medicaid. A few commenters also referenced estimates generated by independent consulting firms, one of which predicted Medicaid enrollment would increase by 30 million as a result of the adverse economic effects from the COVID-19 PHE. To this end, many stakeholders urged CMS to use more recent, or alternative data sources, to account for the projected increase in Medicaid beneficiaries in the calculation of Factor 1.

A commenter also observed that due to the COVID-19 PHE, disproportionate patient percentages (DPPs) would be expected to increase nationwide in FY 2021, increasing the projected amount of traditional DSH payments above the levels originally projected based on the economic assumptions and actuarial analysis used in the President's Budget. Finally, a handful of commenters raised the issue of deferral of inpatient non-emergency services due to the COVID-19 PHE, suggesting that these services would likely be shifted to next year, and expressing concern about the impact that this shift might have on the calculation of Factor 1 for FY 2021. Some commenters suggested that the agency take into account the shift in hospital payer mix resulting from the COVID-19 PHE, as well as hospital case volume degradation, when updating its estimates of DSH payments.

Response: We have taken into consideration the concerns commenters have raised as a result of the COVID-19 PHE in making our projection of Factor 1 for this FY 2021 IPPS/LTCH PPS final rule. We thank the commenters for their input on impact projections, such as the impact on Medicaid enrollment from the COVID-19 PHE. In updating our estimate of Factor 1, we considered, as appropriate, the same set of factors that we used in the proposed rule, as

updated to account for the unique economic situation presented by the COVID-19 PHE. We note that the estimated increases in new Medicaid enrollees used for Factor 1 are generally consistent with the updated Factor 2 calculation described in the next section. The updated factors for "Discharges" and "Case Mix" incorporate the latest estimates from OACT of the impact of COVID-19 on the Medicare program. We discuss further details on the updated Factor 1 estimate and data sources in this section of the rule as part of the discussion of the final Factor 1 estimate for FY 2021.

After consideration of the public comments we received, we are finalizing, as proposed, the methodology for calculating Factor 1 for FY 2021. We discuss the resulting Factor 1 amount for FY 2021 in this section. For this final rule, the OACT used the most recently submitted Medicare cost report data from the March 31, 2020 update of HCRIS to identify Medicare DSH payments and the most recent Medicare DSH payment adjustments provided in the Impact File published in conjunction with the publication of the FY 2020 IPPS/LTCH PPS final rule and applied update factors and assumptions for future changes in utilization and case-mix to estimate Medicare DSH payments for the upcoming fiscal year. The July 2020 OACT estimate for Medicare DSH payments for FY 2021, without regard to the application of section 1886(r)(1) of the Act, was approximately $15.171 billion. This estimate excluded Maryland hospitals participating in the Maryland All-Payer Model, hospitals participating in the Rural Community Hospital Demonstration, and SCHs paid under their hospital-specific payment rate. Therefore, based on the July 2020 estimate, the estimate of empirically justified Medicare DSH payments for FY 2021, with the application of section 1886(r)(1) of the Act, was approximately $3.793 billion (or 25 percent of the total amount of estimated Medicare DSH payments for FY 2021). Under § 412.106(g)(1)(i) of the regulations, Factor 1 is the difference between these two

estimates of the OACT. Therefore, in this final rule, Factor 1 for FY 2021 is $11,378,005,107.01, which is equal to 75 percent of the total amount of estimated Medicare DSH payments for FY 2021 ($15,170,673,476.01 minus $ 3,792,668,369.00). The Office of the Actuary's final estimates for FY 2021 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	1.0336	1.0530	14.747
2019	1.0185	0.966	1.009	1.02035	1.0129	14.937
2020	1.031	0.891	1.039	1.01957	0.9731	14.536
2021	1.029	1.036	0.983	0.99595	1.0437	15.171

*Rounded.

In this table, the discharges column shows the changes in the number of Medicare fee-for-service (FFS) inpatient hospital discharges. The figures for FY 2018 and FY 2019 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 2020 is based on preliminary data for 2020. The discharge figure for FY 2021 is an assumption based on recent trends recovering back to the long-term trend and assumptions related to how many beneficiaries will be enrolled in Medicare Advantage (MA) plans. The discharge figures for 2020 and 2021 include the estimated impact of the COVID-19 pandemic. The case-mix column shows the estimated changes 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 increase is based on preliminary data. The FY 2021 figure is an estimate based on the recommendation of the 2010-2011 Medicare Technical Review Panel. The case-mix factor figures for 2020 and 2021 have also been adjusted for the estimated impact of the COVID-19 pandemic. 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 and the 20 percent add on for COVID-19 discharges). 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 and 2019 resided in States that had elected to expand Medicaid eligibility, and 60 percent of all individuals who were potentially newly eligible Medicaid enrollees in 2020 and thereafter, resided in States that had elected to expand Medicaid eligibility. In the future, these assumptions may change based on actual participation by States. The "Other" column also includes the estimated impacts on Medicaid enrollment from the pandemic. We note that it is estimated that Medicaid enrollment increased by 4.0 percent in FY 2020 and will increase by an additional 0.3 percent in FY 2021. For a discussion of general issues regarding Medicaid projections, we refer readers to the 2018 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/MedicaidReport2018.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 81 percent of the average per capita expenditures for a pre-expansion Medicaid beneficiary due to the better health of these beneficiaries. We note that this is an updated assumption based on more recent data compared to the data available at the time of the proposed rule. This same assumption was used for the new Medicaid beneficiaries who enrolled in 2020 and 2021 due to the COVID-19 pandemic. 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	2.4	0	0.0	0.5	2.9

Note: All numbers are based on the 2020 Medicare Trustees Report projections adjusted for more recent data and the estimated impact of the COVID-19 pandemic, except for the FY 2021 percentages, which are based on the most recent forecast, including the estimated impact of the COVID-19. We refer readers to section IV.B. of the preamble of this final rule for a complete discussion of the changes in the inpatient hospital update for FY 2021.

b. Calculation of 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 a statutory adjustment of 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. In the FY 2021

IPPS/LTCH PPS proposed rule (85 FR 32750), we proposed 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 had determined that 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 the FY 2021 IPPS/LTCH PPS proposed rule, we described 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 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) Factor 2 for FY 2021

As discussed in the FY 2021 IPPS/LTCH PPS proposed rule (85 FR 32751), using these data sources and the previously described methodologies, the OACT estimated 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.[433] As required by section 1886(r)(2)(B)(ii) of the Act, the Chief Actuary of CMS has certified those estimates. However, for purposes of this final rule, we note that the OACT has added an addendum to the memo to reflect an updated methodology for uninsured rate projection, as discussed in our responses to comments.

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, 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

[433] Certification of Rates of Uninsured. July 31, 2020. Available at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInPatientPPS/dsh.html.

approach to 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 proposed to continue to apply the weighted average approach used in past fiscal years in order to estimate the rate of uninsurance for FY 2021. As part of the development of the proposed Factor 2 for FY 2021, the OACT 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. However, in the proposed rule, we noted that we might 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 was 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 proposed that Factor 2 for FY 2021 would be 67.86 percent.

The proposed FY 2021 uncompensated care amount was $11,518,901,035.84 * 0.6786 = $7,816,726,242.92. (We note that this calculation is Factor 1 * Factor 2. In the proposed rule, this sentence inadvertently referenced the total amount of estimated Medicare DSH payments before the application of § 1886(r)(1), rather than 75% of that amount, as required by § 412.106(g)(1)(i). However, the proposed total uncompensated care amount was accurately included in the FY 2021 proposed rule and is shown again below).

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

We invited public comments on our methodology for calculating Factor 2 for FY 2021.

Comment: As with the comments received on proposed Factor 1, a majority of commenters discussed the proposed Factor 2 in the context of the adverse economic effects resulting for the COVID-19 PHE. Stakeholders urged OACT to update its projections of the rates of uninsurance for CY 2020 and CY 2021 to reflect changes in the rate of uninsurance due to the COVID-19 PHE, and in particular, the marked increase in the number of unemployed workers. Several commentators also pointed out that, based on the OACT projections, the uninsured rate is expected to remain fairly flat (9.5% in FY 2021 as compared to 9.4% in FY 2020); however, given the proposed decrease of $534 million in the estimate of the amount available to make uncompensated care payments from the FY 2020 level, many commenters urged CMS to use more recent or alternative data sources to account for the increase in the rate of uninsurance due to the COVID-19 PHE. Several commenters highlighted CMS' statement in the proposed rule that it could consider more recent data that may become available for the calculation of the final Factor 2 for FY 2021.

Many commenters cited the substantial increase in the unemployment rate, and the likely loss of employer-sponsored health insurance, as the main factor influencing the uninsured rate

since the outset of the COVID-19 PHE. Commenters referenced various sources for the unemployment rate, including estimates from the Bureau of Labor Statistics as well as from independent research groups. Several commenters also proposed updated estimates of the uninsured rate and alternative approaches on how to adjust Factor 2 and the estimated uncompensated care amount to reflect the impact of the COVID-19 PHE. A commenter raised the idea of using the correlation between the unemployment rate and the uninsured rate, which they projected to be 21.86%, by arguing that the uninsured rate is approximately 2.86 times the unemployment rate. Considering this relationship, the commenter estimated the uncompensated care amount for FY 2021 should be $18 billion. The commenter further suggested that the increase in uncompensated care payments from the proposed amount could be funded by the CARES Act.

Several different estimates of the uninsured percentage were suggested by other stakeholders. Those who cited the Kaiser Family Foundation estimated that 3.8 million of the newly unemployed would remain uninsured in January 2021. A commenter stated that this would increase the number of uninsured to 35.3 million and, therefore, would increase Factor 2. Another stakeholder, also citing the Kaiser Family Foundation estimate, added that it would be unrealistic to assume that only 3.8 million people would remain uninsured in 2021 because not everyone eligible for coverage in the Affordable Care Act (ACA) exchanges or Medicaid would actually enroll in such coverage. The commenter suggested that an optimistic estimate of those actually enrolling would be closer to 75% of the newly uninsured; given this assumption, the commenter indicated that the uninsured number would actually increase by 9.6 million or 2.6 percentage points, which would increase the uncompensated care amount by 2.3 billion dollars. Several other commenters echoed this concern, stating that there is no guarantee that

individuals losing ESI would actually enroll in alternative forms of coverage, primarily Medicaid and plans available through the ACA exchanges. For example, a commenter stated that previous estimates have shown that only 43% of ACA exchange eligible enroll, adding that increased Medicaid eligibility is limited to expansion states, further limiting potential enrollment.

Other commenters provided estimates developed by consulting groups of both the uninsured rate and the uncompensated care amount. For example, a commenter referenced an estimate that the total uninsured population could increase to 40 million due to the COVID-19 PHE and indicated that inputting this number into the estimate based on the National Health Expenditure Accounts (NHEA) would result in an uninsured rate of 11% to 12%. The resulting increase in Factor 2 would translate to more than one billion dollars in additional funds for uncompensated care payments. Another commenter simulated the uncompensated care amount based on the uninsured and Medicaid enrollment estimates from the Urban Institute and the Kaiser Family Foundation and found that the uncompensated care amount would be closer to $10 billion. A handful of commenters also suggested that CMS maintain the same level of uncompensated care funding as in FY 2020.

Several commenters urged that CMS revise its methodology for estimating Factor 2 to incorporate the effects of COVID-19 on the uninsured rate in FY 2021 and the impact of any future public health emergency.

Lastly, commenters urged CMS to be transparent in the calculation of Factor 2 and stated that agency assumptions and data sources should be accurate and publicly available.

Response: We thank the commenters for their input and their recommendations regarding the estimate of Factor 2 included in the proposed rule. Considering the unprecedented impact of the COVID-19 PHE and that more recent available data regarding levels of uninsurance have

become available since the proposed rule, OACT has updated the projection of the rate of uninsurance for purposes of calculating the final Factor 2 for FY 2021. We refer readers to the addendum to the OACT memo for further details on the methodology and updated assumptions used in the calculation of the projection of the uninsurance rate. In brief, using the past estimates from NHEA from earlier this year as a baseline, OACT estimated the impacts of employment changes on insurance coverage to update the estimate of rates of uninsurance. We note that this approach takes into account more recent historical data on the rate of unemployment as published by BLS, as well as updated economic projections of those data, as published in the monthly Blue Chip Economic Indicators report, to better reflect the estimated impacts of the PHE. Regarding the commenters' suggestion for revising the Factor 2 methodology more generally to reflect the impact of public health emergencies, such as the COVID-19 PHE, we may take this recommendation into consideration for future rulemaking, as appropriate.

In response to the comments concerning transparency, we reiterate that we have been and continue to be transparent with respect to the methodology and data used to estimate Factor 2. The FY 2021 IPPS/LTCH PPS proposed rule included a detailed discussion of our proposed Factor 2 methodology as well as the data sources that would be used in making our final estimate. For purposes of this final rule, we are using an updated projected rate of uninsurance to reflect the impact of the PHE for the COVID-19 pandemic. A detailed description of the methodology used to update our estimates can be found in the accompanying memo (available at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh) . Section 1886(r)(2)(B)(ii) of the Act permits us to use a data source other than the CBO estimates to determine the percent change in the rate of uninsurance beginning in FY 2018. We continue to believe that the NHEA data and methodology that were used to estimate Factor 2 for this final

rule are transparent and best meet all of our considerations for ensuring reasonable estimates for the rate of uninsurance that are available in conjunction with the IPPS rulemaking cycle. We further believe, given the unprecedented effects on health insurance enrollment as a result of COVID-19, that it is appropriate to update the NHEA-based projection of the FY 2021 rate of uninsurance that appeared in the proposed rule using recent relevant unemployment data from BLS, and associated projections of that metric as published in the Blue Chip Economic Indicators report, to account for these expected impacts.

After consideration of the public comments we received, we are updating the calculation of Factor 2 for FY 2021 to incorporate more recent data. The final estimates of the percent of uninsured individuals have been certified by the Chief Actuary of CMS. The calculation of the final Factor 2 for FY 2021 using a weighted average of OACT's updated 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: 10.3 percent.
- Percent of individuals without insurance for CY 2021: 10.2 percent.
- Percent of individuals without insurance for FY 2021 (0.25 times 0.103) + (0.75 times 0.102): 10.2 percent.

1- |((0.0102-0.14)/0.14)| = 1-0.2714 = 0.7286 (72.86 percent). Therefore, the final Factor 2 for FY 2021 is 72.86 percent. The final FY 2021 uncompensated care amount is $ 11,378,005,107.01 * 0.7286 = $ 8,290,014,520.96.

c. Calculation of 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 was 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 believed 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 were 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) Methodology for Calculating Factor 3 for FY 2021 and Subsequent Fiscal Years

(a) Use of 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 were available in time for the development of the 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), in the FY 2021 IPPS/LTCH PPS proposed rule (85 FR 32755), we stated that 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 the 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. As explained in the FY 2021 IPPS/LTCH proposed rule, 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 proposed 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 proposed to continue to use the low-income insured days proxy to calculate Factor 3 for these hospitals for one more year. We noted that the uncompensated care payments to hospitals whose FY 2017 Worksheet S–10 data had been audited represented

approximately 65 percent of the total uncompensated care payments for FY 2021. For purposes of the FY 2021 proposed rule, we used a HCRIS extract updated through February 19, 2020. We noted that we intended 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 invited the public to submit comments on this intention regarding the use of the March update of HCRIS, and indicated that we might 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.

Comment: Several commenters expressed concern about the redistribution of uncompensated care payments in the context of CMS not using the most recent and accurate HCRIS data. To this end, several commenters urged CMS to use the latest HCRIS extract available for the calculation of Factor 3. Among these commenters, the majority preferred the use of a June 30 HCRIS extract, pointing out that CMS has used a June quarterly extract in both the FY 2018 and FY 2019 IPPS/LTCH PPS final rules. Commenters reasoned that using a later HCRIS extract would allow providers more flexibility to amend materials that may have been overlooked in the proposed rule, and according to commenters, this is especially important due to the effect of the COVID-19 PHE. A commenter suggested CMS use a HCRIS extract as close as possible to the close of the comment period for the FY 2021 rulemaking cycle. Another commenter suggested the agency use the February or March HCRIS data extract for future proposed rules and the June HCRIS extract for FY 2021 and future final rules, mentioning that this would allow for more time to complete the audits, to contest results, and to handle unforeseen circumstances or delays. Additionally, a commenter expressed concern that if CMS

did not use the June 30 HCRIS extract in the FY 2021 final rule, then their most recent CCR would not be accounted for, placing their hospital above the proposed CCR trim ceiling.

Response: We thank commenters for sharing their concerns regarding the HCRIS extract used in the FY 2021 IPPS/LTCH final rule. We agree with commenters that recommended using the June 2020 HCRIS data for calculating Factor 3 for FY 2021, due to this year's public health emergency, which, for some hospitals, delayed the filing of amended cost report information and/or correction of report version discrepancies in time for the March HCRIS extract; therefore we are finalizing the use of the June 30 HCRIS extract to calculate Factor 3 for this FY 2021 IPPS/LTCH PPS final rule. We believe on balance this is the best available data for purposes of calculating Factor 3 for FY 2021. In the rare situations where a MAC mishandled a report in the upload process, such as by accepting an amended report, reopening a report, and/or adjusting uncompensated care cost data on a report before the June 30 cut off, but the corrected uncompensated care cost data were inadvertently omitted from the June 30, 2020 extract of the HCRIS, we used the corrected version of the report after confirming the appropriate report version with the applicable MAC.

Regarding commenters' suggestions that we use the February or March HCRIS for all future proposed rules, we note that at this time, we intend to use the most recent data available for the applicable rulemaking, which generally means the respective December HCRIS extract for purposes of Factor 3 calculations in future proposed rules. We expect that the December HCRIS extract would reflect the completed Worksheet S-10 audit results available in time for development of the respective proposed rules and the respective HCRIS extract public use files, which are posted on the CMS website quarterly, would also include the most recent audited cost report information for the applicable fiscal year, and be available for public scrutiny.

Furthermore, as noted in the FY 2021 IPPS/LTCH PPS proposed rule, we continue to intend to use the respective March HCRIS for future final rules. We expect the COVID-19 PHE will not have the same impact on future rulemaking as it did for the FY 2021 rulemaking. However, we may revisit this topic of the appropriate HCRIS extract, if necessary, in future rulemaking.

Comment: A large majority of comments expressed general support for the use of Worksheet S-10 to estimate each hospital's share of uncompensated care costs in FY 2021, FY 2022, and/or in future years. Some commenters argued that audited Worksheet S-10 data are more accurate as compared to the proxy method previously used, and others commended CMS for its efforts to improve the data through revised instructions and audits. A few commenters expressed opposition to using Worksheet S-10 data and recommended that CMS reconsider using it for the calculation of uncompensated care costs, especially in the absence of auditing all DSH-eligible hospitals. A commenter expressed concern about the accuracy of Worksheet S-10 data and noted that even with the audits, hospitals are reporting charity care and defining write-offs inconsistently and suggested CMS consider alternative methods to the Worksheet S-10 in consultation with hospitals.

Another commenter asserted that using Worksheet S-10 data to calculate Factor 3 could result in an inequitable distribution because Worksheet S-10 does not "offset hospital UC [uncompensated care] losses with non-Medicare sources of subsidies such as Medicaid DSH and related Medicaid waiver [uncompensated care] pool funds." Other commenters requested additional standardization in the reporting of uncompensated care. A commenter expressed concern that the data reported by hospitals may not be comparable across all hospitals noting, for example, a difference of opinion among hospitals about characterizing "denied claims as charity care if the hospital's financial assistance policy says the patient is not responsible for payment,

even though that is a contractual or government payment requirement." Another commenter noted a case where discounts for uninsured and underinsured patients required by state mandates were disallowed by a MAC because such mandates were not covered by their charity care policy.

Response: We appreciate the support for our proposal to use Worksheet S-10 data for the computation of Factor 3. We also appreciate the input from those commenters who are opposed to the use of data from Worksheet S-10 in the calculation of Factor 3. Regarding those comments which note that the Worksheet S-10 data are not accurate, and that the use of the Worksheet S-10 data should be reconsidered on that basis, we note that as described in the FY 2021 IPPS/LTCH PPS proposed rule, we proposed to continue to use Worksheet S-10 cost report data in FY 2021 based upon the results of analyses of Worksheet S-10 data, conducted both internally and by stakeholders, which demonstrate that Worksheet S-10 accuracy has improved over time. As part of our ongoing quality control and data improvement measures, we have revised the cost report instructions (Transmittal 11). We have conducted audits of the FY 2017 Worksheet S-10 data, and have now begun auditing the FY 2018 Worksheet S-10 data for an expanded number of hospitals to further improve provider reporting and overall accuracy. Moreover, as hospitals gain more experience with completing the Worksheet S-10 and build upon lessons learned from the audits, we believe the data obtained from these cost reports will continue to improve and become more consistent. Therefore, we have concluded that the Worksheet S-10 data is the best available source for the uncompensated care costs of subsection (d) hospitals.

Comment: Many commenters supported the use of a single year of FY 2017 Worksheet S-10 data for the calculation of Factor 3 for FY 2021. Commenters noted that the FY 2017 cost reports are the most recent reports which have been subject to audit and that these audits have continued to improve the accuracy and reliability of Worksheet S-10 data over time. Supporters

of this proposal also argued that FY 2017 Worksheet S-10 data have been audited and stated that audited hospitals are expected to receive 65 percent of the proposed total uncompensated care payments for FY 2021. A handful of commenters also pointed out that it would be inappropriate to blend audited data with unaudited data, which could lead to inaccurate and non-representative uncompensated care payments for some hospitals if the unaudited cost reports contained reporting errors. In addition, several commenters indicated that the FY 2017 cost reports reflect the first year of reported data under the most recent revised Worksheet S-10 instructions, which were effective for cost reporting periods beginning on or after October 1, 2016.

Many commenters expressed opposition to using a single year of Worksheet S-10 data for the calculation of FY 2021 uncompensated care payments and for future years. The primary concern expressed by these stakeholders was the possibility that such an approach would lead to significant variation in year-to-year payments, especially in light of outside factors that may affect a hospital's finances. These commenters pointed to CMS's historical practice of using data from multiple years to determine uncompensated care payments and argued that such an approach would mitigate year-to-year fluctuations and avoid a skewed distribution of uncompensated care payments. To this end, a commenter noted that some hospitals reported extreme changes in uncompensated care costs from FY 2017 to FY 2018 and according to the commenter, in one example, the change was over 500 percent. The commenter added that less than one-third of hospitals reported changes in uncompensated care that were less than ten percent.

The most common alternative proposal among commenters who opposed the use of a single year of FY 2017 data for the calculation of Factor 3 in FY 2021 was the use of three years of historical Worksheet S-10 data. A commenter specifically suggested the use of FY 2015, FY

2016, and FY 2017 Worksheet S-10 data. Another commenter recommended that CMS use FY 2014, FY 2015, and FY 2016 data as a transition policy. Other commenters recommended a blend of FY 2015 and FY 2017 data since both years were subject to audits. Similar to this alternative, another commenter proposed that for the allocation of FY 2021 uncompensated care payments, CMS use a 50/50 blend, derived from the FY 2020 Factor 3 and a Factor 3 calculated using FY 2017 Worksheet S-10 data. There was also a commenter that requested that we maintain total national uncompensated care payments at the same level as in FY 2020.

Some stakeholders offered suggestions regarding the uncompensated care payment calculation that appear outside of the scope of the proposed methodology. Such recommendations included that CMS change the distribution of uncompensated care payments so that the allocation is based not on only uncompensated care costs but also on the disproportionate share percentage (DPP); set a cap on per discharge uncompensated care payments not to exceed 100 percent of DRG amounts; establish a transition period for hospitals facing a significant (5 percent) decrease in uncompensated care payments for a given year; and reevaluate the uncompensated care payment formula to achieve parity between rural and urban payments. In addition, some commenters requested that we consider adjusting uncompensated care costs in this FY 2021 rulemaking to reflect the impact of the COVID-19 PHE, rather than waiting until FY 2024 or FY 2025 when the current year's data (FY 2020) may be used for uncompensated care payment calculations. In relation to this recommendation, a commenter noted that, while the effect of the COVID-19 PHE would vary based upon geographic areas, they would expect a redistributional impact on future uncompensated care payments, and suggested that CMS begin to consider ways to dampen potential downward fluctuations in uncompensated care costs at the hospital level.

Response: We are grateful to those commenters who expressed their support for our proposed policy of using the FY 2017 Worksheet S-10 data to determine each hospital's share of uncompensated care costs in FY 2021. As noted in the FY 2021 IPPS/LTCH PPS proposed rule, we believe, that, on balance, 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 unaudited FY 2016 and/or (audited or unaudited) FY 2015 data, we potentially would be diluting the effect of our considerable auditing efforts and introducing unnecessary variability into the calculation if we were to use multiple years of data to calculate Factor 3.

We also note that if, for example, a blend of FY 2015, FY 2016, and/or FY 2017 cost report data were to be used, some hospitals in states that expanded Medicaid eligibility during this time period may have experienced significant reductions in uncompensated care costs following the expansion due to increased Medicaid coverage covering many previously uninsured individuals. In this situation, if an average that included pre-expansion uncompensated care cost data were used, the Factor 3 calculated for the hospital may be a less accurate reflection of the relative uncompensated care burden of the hospital. Thus, we believe using only the FY 2017 cost report data will result in a more accurate and more updated reflection of each hospital's proportion of uncompensated care costs. We also agree with those commenters that noted FY 2017 cost reports reflect the first year of data reported under the revised to Worksheet S-10 instructions through Transmittal 11, which further improved the data quality. Accordingly, we are finalizing without modification our proposal to use FY 2017 cost report data, which we believe is the best available data, to calculate Factor 3 for FY 2021.

For the same reasons, we also continue to 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 continue to believe that establishing a policy that would apply not only for FY 2021, but also for all subsequent fiscal years would provide greater predictability regarding the basis for determining future uncompensated care payments.

Regarding the commenters' suggestion to adjust uncompensated care costs in this rulemaking to reflect the impact of the COVID-19 PHE, even if such a policy change were appropriate for FY 2021 it is not clear what the methodology would be for determining such an adjustment and what data source could be used. Because the cost reporting data from the COVID-19 PHE time period is not yet available to be analyzed, we believe it would be premature to attempt in this rulemaking to modify the methodology for determining uncompensated care payments for a future year specifically to address the impact of the COVID-19 PHE. We will consider this issue further in future rulemaking, if appropriate.

Regarding commenters' concerns and suggestions that were outside of the scope of the proposed rule's methodology, separate from the cost report years from historical Worksheet S-10 data, we appreciate commenters' input and note that we may consider these and other considerations in future rulemaking.

The following comments relate to the Worksheet S-10 audit process:

Comment: As in previous years, the auditing process for the FY 2017 Worksheet S-10 was a common topic among many commenters. Several commenters agreed that the data from audited FY 2017 Worksheet S-10s have improved in accuracy when compared to previous years of data, including the data used to calculate Factor 3 under the proxy methodology in previous

years. Other commenters also commended CMS's efforts to improve the Worksheet S-10 data through the audit process and revised instructions.

Still, many commenters expressed concerns with the Worksheet S-10 audits. Some commenters recommended that CMS implement a comprehensive audit process, similar to the audit process used for the wage index noting that Worksheet S-10 audits should include the same level of scrutiny. Many commenters requested that CMS establish a standardized, streamlined process across auditors, which would include uniform templates for cost report submissions, acceptable documentation regarding audit requirements, and consistent timelines for information submissions. A commenter noted that their hospitals faced significant reporting burden providing auditors with the necessary audit documentation and communicating between MAC auditors, which delayed their Worksheet S-10 audits.

Stakeholders also urged CMS to conduct consistent and equitable audits across providers. Others suggested that CMS set a clear timeframe for communication and revisit the scope of the audits to target specific data elements, which would decrease provider burden. Related to this, another commenter requested that CMS work with the MACs to streamline the audit process and avoid situations where hospitals would have to resubmit data in a different template, which would only add administrative burden on hospitals.

To this end, a commenter proposed that CMS clarify that MACs can only request documentation referenced in hospitals' Financial Assistance Policies (FAP), as well as confirm that the purpose of the Worksheet S-10 audits is to check if hospitals are following their FAP. Additionally, commenters advised CMS to minimize the administrative burden of excessive reporting requirements imposed by the MACs, such as requests for overly detailed information

like patients' social security numbers and birth dates, and the solicitation of information not yet generally available in hospitals' financial recordkeeping systems.

Additionally, several commenters suggested that CMS ensure transparency in the audit process by making the audit materials and protocols publicly available. They also urged CMS to develop a transparent timeframe for the audit process, with adequate lead time and communication to providers about expectations. Commenters also requested that CMS disclose the criteria used to identify hospitals subject to audits, and prepare communications regarding expectations for the audit and any audit guidance before the rulemaking cycle. A commenter noted that CMS's "policy of opacity" only results in inconsistent interpretations of audit guidance by the MACs. Other commenters made recommendations regarding the timeliness of the audits, such as following a set annual timeframe similar to the approach used in the wage index audits.

Commenters also expressed discontent regarding the limited time allowed for providers to respond to adverse adjustments, resolve differences, and submit supporting documentation. These commenters urged CMS to begin the audits in a timely manner to avoid situations with short response times. Regarding the audit timeline, a commenter proposed that CMS begin the audit process on an annual basis in February or March, with the end date remaining December 31 of the applicable year. According to this commenter, the proposed timeline would provide MACs sufficient time to work with providers and to schedule Worksheet S-10 audits.

Additionally, commenters urged CMS to consider working with MACs in developing the Worksheet S-10 audit process to further promote clarity and consistency. To this end, a commenter requested that in developing Worksheet S-10 audit protocols, CMS consider using one MAC either to do all of the audits or to develop the audit rules to be employed by all MACs. A different commenter noted that there are hospital systems subject to audits conducted by

multiple MACs, and these providers have observed inconsistent audit adjustments to uncompensated care amounts. This commenter noted that these inconsistencies are indicative of MACs not interpreting and following CMS's audit instructions in a standardized way.

Commenters noted the need for a timely review and timely appeals process for any Worksheet S-10 errors or inconsistent audit disallowances. As part of raising their concern regarding the lack of an appeals process for Worksheet S-10 audits, a commenter proposed that disallowed uncompensated care costs be appealed to the Provider Reimbursement Review Board (PRRB), which the commenter asserted would be consistent with the process used to appeal other items from the Medicare cost report. Another commenter asserted that there would not be sufficient time to appeal audit disallowances or adjustments under a normal PRRB process before the data are used by CMS. Some commenters recommended that CMS establish an expedited process for appeal to an appropriate oversight body, which would allow hospitals to obtain reversals of errors by MACs and address any inconsistencies and/or improper disallowances. A commenter suggested the use of an abbreviated appeals process, similar to the process used in the wage index development process.

Commenters also provided additional recommendations for future audits specifically to improve data consistency. They suggested that CMS audit all hospitals and utilize a single auditor, or at least establish and enforce a formal and uniform audit process. Several commenters recommended using a similar approach to the desk review process conducted for the purposes of the wage index. Many commenters expressed concerns that not all providers have had their Worksheet S-10 data audited. For example, a commenter noted that while some hospitals have been audited more than once, other DSH hospitals have not been audited at all. Some commenters urged CMS to complete audits for the remaining hospitals that did not have the

Worksheet S-10 from their FY 2017 cost report audited before the FY 2021 rulemaking and others strongly felt that CMS should audit all DSH-eligible hospitals on an ongoing basis. A commenter stated that if CMS cannot audit 100 percent of hospitals, the agency should focus on the biggest recipients of DSH payments.

A commenter requested clarification of whether Sole Community Hospitals (SCHs) that are paid under their hospital-specific rates are subject to the Worksheet S-10 audits. Similarly, a few commenters suggested that SCHs should be excluded from the Worksheet S-10 audits to improve efficiency and reduce burden, as they are not eligible for DSH payments and their data are not included in the totals used for allocation of uncompensated care payments. A commenter asserted that there is a lack of justification for a requirement to audit data that is of no use for Medicare payment purposes. A commenter suggested that non-DSH eligible SCHs zero out uncompensated care on the Worksheet S-10, but also recognized that this approach may not be beneficial as it would appear as if the hospitals are not providing any uncompensated care.

Finally, a few commenters suggested new approaches to auditing and/or reviewing Worksheet S-10 data. A commenter recommended that CMS establish a program of periodic timely data review for the identification of discrepancies and troublesome data. This commenter also proposed that CMS start the process of reviewing FY 2019 cost data as it is reported, and that CMS to engage in FY 2018 data audits during FY 2021 for hospitals that are projected to receive DSH payments, but have not yet been audited. Another commenter recommended that in order to utilize resources more efficiently, CMS could work with the Internal Revenue Service (IRS) as it also audits hospital uncompensated care costs reported on the Form 990 and both agencies have similarly aligned goals. They also suggested that CMS continue Worksheet S-10 audits, but explore ways in which it can more efficiently utilize audit resources, such as, by

relying on hospitals' audited financial statements. In addition, this commenter requested that CMS apply the same audit criteria that are used for retrospective audits of empirically justified DSH payments, which use SSI/Medicare and Medicaid eligible days/indigent care days. The commenter also stated that hospitals should have the same protections afforded by the appeal rights for empirically justified DSH payments.

Response: We thank commenters for their feedback on the audits of the FY 2017 Worksheet S-10 data and their recommendations for future audits. As we have stated previously in response to comments regarding audit protocols, these are provided to the MACs in advance of the audit so as to assure consistency and timeliness in the audit process. We began auditing the FY 2017 Worksheet S-10 data for selected hospitals last year so that the audited uncompensated care data for these hospitals would be available in time for use in the FY 2021 IPPS/LTCH PPS proposed rule. We chose to focus the audit on the FY 2017 cost reports in order to maximize the available audit resources. We note that FY 2017 is the first year of data under the revised cost report instructions included in Transmittal 11. In response to the consistent feedback from commenters emphasizing the importance of audits in ensuring the accuracy and consistency of data reported on the Worksheet S-10, we have also started the process of auditing FY 2018 Worksheet S-10 data.

Regarding commenters' recommendations to establish an audit and appeals process for the Worksheet S-10 similar to the process used for the wage index audits, at this point we do not plan on introducing such a process in order to maximize limited audit resources. Attempting to replicate the wage index audit process would exceed our current audit resources and require shifting resources from other audit work, for example potentially negatively impacting the wage index audit itself in the attempt to replicate it. The wage index impacts a far greater proportion

of national hospital payments than the proportion impacted by Medicare uncompensated care payments. We appreciate all commenters' input and recommendations on how to improve our audit process and reiterate our commitment to work with the MACs and providers on audit improvements, including changes to increase the efficiency of the audit process, building on the lessons learned in previous audit years.

We also appreciate the different suggestions for a potential audit timeline. We thank the commenters for their suggestions, but at this time, we do not intend to establish fixed start date for audits across MACs so that we can retain the flexibility to use our limited audit resources to address and prioritize audit needs across all CMS programs each year. We note that MACs work closely with providers regarding scheduling dates during the Worksheet S-10 audit process..

Regarding commenters' requests to make public the audit instructions and criteria, as we previously stated in the FY 2020 IPPS/LTCH final rule (84 FR 42368) and prior rules, we do not make review protocols public as CMS desk review and audit protocols are confidential and are for CMS and MAC use only. Additionally, we recognize that a number of commenters suggested we audit all hospitals. We note that limited resources do not allow us to audit all providers. However, as discussed in the FY 2021 IPPS LTCH PPS proposed rule (85 FR 32756), the proposed uncompensated care payments to hospitals whose FY 2017 Worksheet S-10 data have been audited represented approximately 65 percent of the proposed total uncompensated care payments for FY 2021, which is an increase from the FY 2015 audits. Also, we are in the process of auditing FY 2018 Worksheet S-10 data and expect that the number of audits conducted will continue to increase over time, resulting in improved Worksheet S-10 data over the years as more cost report years are audited.

Concerning the suggestions to exclude Sole Community Hospitals (SCHs) from audits of Worksheet S-10 when the hospitals are paid under their hospital-specific rate, we note that all hospitals are required to maintain documentation for cost reporting, including Worksheet S-10. We also note that there may be some uncertainty whether a hospital will ultimately be paid based on its hospital specific rate, since that review occurs during settlement process through the cost report. For example, there may be timing considerations with projecting which SCHs will be paid under the IPPS Federal rate, in addition SCH status may change over time.

Regarding the recommendation that we review FY 2019 data as they are reported, we note that time and audit resources are limited, and as discussed previously, we are currently in the process of reviewing FY 2018 Worksheet S-10 data, which is the most recent year of broadly available cost report data. With respect to the comment recommending that we work with the IRS to utilize audit resources more efficiently, we note that the instructions for the IRS' Form 990 are not the same as for the Worksheet S-10. In addition, we note that the requirement to report on the IRS Form 990 is limited to non-profit hospitals.

Concerning the request to apply the same audit criteria that are used for empirically justified DSH payments, those audit protocols are also confidential and are for CMS and MAC use only, and we continue to believe that audit protocols (e.g. critieria) should be confidential, so we disagree with commenter to make public any audit protocols To the extent that the commenter is implying that the confidentiality of the audit protocols causes inconsistency in auditing across the MACs, we also disagree and will continue to work with the MACs each year to ensure a consistent audit process across providers and MACs.

As noted in earlier discussion, after consideration of the comments received we are finalizing without modification our proposal to use Worksheet S-10 data from FY 2017 cost

reports to calculate Factor 3 for FY 2021 for all hospitals, with the exception of IHS and Tribal hospitals and Puerto Rico hospitals.

(b) Use of the 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 proposed 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. In the FY 2021 IPPS/LTCH PPS proposed rule (85 FR 32756), we noted that we intended to consider the comments received on this proposal for FY 2022 and subsequent fiscal years, and might revisit it either in the final rule or through future rulemaking.

Comments: A few commenters supported the use of a single year of audited Worksheet S-10 data for FY 2022 and subsequent years. In contrast, while the majority of commenters supported the use of one year of FY 2017 Worksheet S-10 data for FY 2021 uncompensated care payments, most commenters argued for a transitional period where ultimately multiple years of audited Worksheet S-10 data would be used to determine Factor 3 for future years, especially

when sufficient years of audited data reported under the revised reporting instructions are available. According to these commenters, such an approach would mitigate year-to-year fluctuations in uncompensated care payments. A commenter stated that it is impossible to foresee what potential shortcomings in the data or concerns with the audit process could arise. Many commenters urged CMS not to finalize the policy of using the most recent year of audited Worksheet S-10 data beyond FY 2021. These commenters believed that finalizing the proposal would prevent opportunities to assess and comment on peculiarities in the data to be used in determining Factor 3 for future years

Consistent with these recommendations, a commenter proposed that for FY 2022 equally weighted blocks of audited FY 2017, FY 2018, and "preliminarily-reviewed" FY 2019 Worksheet S-10 data be used to determine Factor 3 with a rolling three-year average applied moving forward. There was also a handful of commenters that requested a three-year average as a phased approach. For example, a commenter suggested that FY 2017 and FY 2018 Worksheet S-10 data be used for the FY 2022 payments and then a rolling three-year average beginning with FY 2023. Additionally, commenters recommended that CMS monitor payments over time to assure data anomalies are addressed. To this end, a commenter urged CMS to allow for monitoring and review of uncompensated care payment volatility and audits of all hospitals' Worksheet S-10 data, before implementing the use of a single year of Worksheet S-10 data for FY 2022 and subsequent years.

Some commenters acknowledged the efforts CMS has taken to improve the accuracy of Worksheet S-10 data through the FY 2015 and FY 2017 audit process. A commenter provided an analysis that indicated the audits have improved the reliability and accuracy of Worksheet S-10

data. Another commenter indicated their support for the processes implemented by CMS and the MACs to ensure the integrity of Worksheet S-10 data.

Still, several commenters expressed concerns about the accuracy of Worksheet S-10 data. Some commenters recommended CMS implement a fatal cost report edit on Worksheet S-10 to guarantee completeness and consistency in reporting. Another commenter requested that CMS provide a 14-day period for hospitals to submit corrections arising from the mishandling of data by MAC and/or CMS. While this commenter recognized that these situations are uncommon, they urged that a 14-day time period would be sufficient to improve the uncompensated care cost allocation and would be consistent with the 15-day period we proposed to allow for review and correction of merger listings following the publication of this final rule.

Response: We thank commenters for their continued concern regarding the accuracy of Worksheet S-10 data and for their constructive feedback. As noted by some commenters, our continued efforts have improved the accuracy for Worksheet S-10 data. We believe that continued use of Worksheet S-10 for the calculation of Factor 3 along with the revisions made to the instructions through Transmittal 10 (November 2016) and Transmittal 11 (September 2017), as well as the FY 2015 and FY 2017 audits, will improve the accuracy, consistency, and quality of the reported data.

We believe using the most recent audited data available before the applicable Federal fiscal year will more accurately reflect a hospital's uncompensated care costs, as opposed to averaging multiple years of data. Consistent with the discussion in the previous section, if a hospital has relatively different data between cost report years, we potentially would be diluting the effect of our considerable auditing efforts and introducing unnecessary variability into the calculation if we were to use multiple years of data to calculate Factor 3. Therefore, we believe

using a single year of audited cost report data is an appropriate methodology for FY 2022 and subsequent years.

Concerning the suggestion that implement a fatal edit on Worksheet S-10, we note that we did not propose any additional edits in the FY 2021 IPPS/LTCH PPS proposed rule. Furthermore, we continue to believe that the ongoing MAC reviews of hospitals' Worksheet S-10 data coupled with our efforts to improve reporting through revised instructions, as well as providers' growing experience with reporting uncompensated care costs outweigh the value of any additional edits to the Worksheet S-10 data. Regarding the suggestion that we allow a 14-day time period for hospitals to submit corrections due to data mishandling, we will revisit the issue in future rulemaking as necessary, and further note that providers will have the opportunity to submit comments on the accuracy of the supplemental data files within 15 business days from the public display of this FY 2021 IPPS/LTCH PPS final rule.

Additionally, we recognize that a number of commenters suggested we audit all hospitals. In response to this, we note that the proposed uncompensated care payments to hospitals whose FY 2017 Worksheet S-10 data were audited represented approximately 65 percent of the proposed total uncompensated care payments for FY 2021, which is an increase from FY 2020 rulemaking in which about approximately half of total uncompensated care payments wereexpected to be made to hospitals whose FY 2015 Worksheet S-10 data had been audited. Further, while our limited resources mean that it is not feasible to commit to auditing all hospitals every year, we note that we expect the number of audits will continue to increase from previous years. We are in the process of auditing FY 2018 data on an expanded number of hospitals.

In the FY 2021 IPPS/LTCH PPS proposed rule, we noted that 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. As discussed in the proposed rule, 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 previously 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, in the FY 2021 IPPS/LTCH PPS proposed rule, we explained our belief that 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 sought comment on this potential restructuring of the Medicare DSH and uncompensated care payments to IHS and Tribal

hospitals beginning in FY 2022. We also noted that we intended to consider input received on this issue through consultation with IHS and Tribal hospitals.

Comment: In response to the discussion in the proposed rule of the unique circumstances of IHS and Tribal hospitals, commenters expressed support for the use of the low-income days proxy in the calculation of Factor 3 for FY 2021. In response to the request for comment on the potential restructuring of Medicare DSH and uncompensated care payments to these hospitals beginning in FY 2022, there were a few commenters that supported the creation of a new payment for IHS and Tribal hospitals consisting of 100 percent of the Medicare DSH amount. However, there were other commenters that requested that CMS provide more time so that the agency can consult with stakeholders on the proposed methodology. Specifically, a commenter requested that at a minimum, an additional year be given so that stakeholders can provide comments on the proposed policy and an additional three years as an implementation phase for the newly developed methodology, adding that an extension of the current proxy methodology would be needed.

Commenters also noted that only two IHS and Tribal hospitals, both of which, have more than 100 beds, would not be subject to the 12 percent cap on DSH payments. The commenters indicated that, in the event uncompensated care payments were to be determined using Worksheet S-10 data, instead of the low income days proxy, these two hospitals would see an increase in their uncompensated care payments, while the remaining 26 facilities would lose $7.5 million. These commenters recommended that CMS mitigate the effect of the cap under the statutory DSH calculation on IHS and Tribal facilities and if this is not possible, a commenter suggested that CMS should work with hospitals on a tailored methodology for the calculation of uncompensated care payments that fits their unique circumstances.

Further a commenter noted that IHS and Tribal Hospitals also face a unique legal standing such that they do not "fit well into the framework that CMS is proposing to adjust for uncompensated care payments." The commenter also added that their inability to charge any Indian for services, even copays, and the provisions contained within treaties with the Federal Government and judicial rulings, means these hospitals face a very unique way of calculating uncompensated care costs and that the calculation of uncompensated care payments should be done in such a way as to maximize their access to federal resources. The commenter suggested that CMS should work with IHS and Tribal facilities as well as the consortium in providing guidance on how these facilities should report uncompensated care on Worksheet S-10. In this regard, another commenter pointed out that "many tribal health programs invest non-Federal resources in their health care programs to furnish care that could easily be classified as uncompensated care because IHCPs [Indian Healthcare Providers] may not charge beneficiaries to receive care and, thus, typically do not have the accounting methods to track these costs." This situation, according to the commenter, makes IHS and Tribal hospitals unable to report charity care and non-Medicare bad debt in a way that is consistent with the current definition of uncompensated care in the current regulation. Additionally, a commenter stated that the information technology systems used by the IHS and Tribal hospitals are not equipped to collect the necessary data for the Worksheet S-10 and that, while these systems have been upgraded, it will take some time, potentially years, before they are fully functional.

A few commenters also requested the continued use of the low-income days proxy in the calculation of Factor 3 for hospitals located in Puerto Rico. In particular, a commenter noted that they are working through challenges in implementing Worksheet S-10 and requested that CMS continue the use of low-income insured days to determine uncompensated care payments for

Puerto Rico hospitals for at least another three years. Another commenter also requested that CMS treat Puerto Rico as it treats other states asserting that "CMS does not include a proper count of low income Medicare beneficiaries that receive services in our hospitals" [Puerto Rico hospitals]. The commenter asserts that CMS only accounts for low income Medicare beneficiaries in the SSI fraction for low income Medicare beneficiaries patients that live on the mainland but travel to Puerto Rico and require hospitalization.

Response: We appreciate the concerns raised by commenters regarding the calculation of Factor 3 for IHS and Tribal hospitals and hospitals located in Puerto Rico. We are not finalizing any policies for FY 2022 for these hospitals and will consider the issues raised by stakeholders in future rulemaking. For FY 2021, we are finalizing our proposal to continue to use the low-income insured days proxy to calculate Factor 3 for these hospitals. In regard to the comment concerning the data used in the SSI fraction for Puerto Rico hospitals, because we are continuing to use insured low-income patient days for uncompensated care in determining Factor 3 for FY 2021, and residents of Puerto Rico are not eligible for SSI benefits, we believe the SSI proxy 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) is still appropriate. In regard to the recommendation that we provide Puerto Rico hospitals a three-year continuation of the current policy before the transition to the use of Worksheet S-10, we invite commenters to provide further input as we revisit the use of Worksheet S-10 data from Puerto Rico hospitals in future rulemaking and assess the FY 2018 audit results from hospitals in Puerto Rico. We are not finalizing the proposal for Puerto Rico hospitals for FY 2022 and subsequent years, because we believe further consideration is necessary. However, we continue to believe Worksheet-S-10 data is the appropriate long term data source for hospitals located in Puerto Rico.

We also appreciate the concerns and input raised by commenters regarding alternative methodologies for the calculation of uncompensated care payments for IHS and Tribal hospitals. We recognize the unique nature of these hospitals and the special circumstances they face, and we reiterate our commitment to continue working with stakeholders, including through tribal consultation, as we revisit the issue of Medicare uncompensated care payments to these hospitals in the FY 2022 rulemaking. As discussed previously, we are not making any changes to the current policy for calculating uncompensated care payments for IHS and Tribal hospitals at this time, and we look forward to continuing to collaborate on methodological approaches in the future.

After consideration of the comments received, we are finalizing the use of low-income insured days proxy to determine Factor 3 for IHS and Tribal hospitals and Puerto Rico hospitals for FY 2021. We are not finalizing a methodology to determine Factor 3 for IHS and Tribal hospitals and Puerto Rico hospitals for FY 2022 and subsequent years at this time because we believe further consideration and review of these hospitals' Worksheet S-10 data is necessary.

(c) 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 proposed 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 the 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). In the FY 2021 IPPS/LTCH PPS proposed rule (85 FR 32757), we noted that the Paper Reduction Act (PRA) package for Form CMS-2552–10 (OMB Control Number 0938–0050, expiration date March 31, 2022) would offer 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.

Comment: In regard to the definition of uncompensated care, several commenters urged CMS to include shortfalls from Medicaid, CHIP, and State and local indigent care programs, which, according to commenters, represent substantial losses as they do not fully cover the cost of providing care. A commenter noted that it is inconsistent that Medicaid patient data is used for DSH eligibility but not for the definition of uncompensated care and provided CMS with methodologies on how to account for Medicaid shortfalls, including specific modifications to Worksheet S-10, such as reporting Medicaid DSH payments on a separate line, separating stand-alone CHIP from the Medicaid line items, and reporting non-DSH supplemental payments separately from Medicaid revenue and Medicaid DSH. The stakeholder notes these suggestions were made in earlier rulemaking years, but not acted upon by CMS. A commenter also argued

that including Medicaid shortfalls in Worksheet S-10 is especially important for hospitals in states that underwent Medicaid expansion, as compared to those that did not, which tend to do better with the current policy.

In contrast, a commenter noted that the unreimbursed portion of the costs of care furnished under state and local indigent care programs should be specifically counted as charity care, while pointing out that Medicaid expansion has helped reduce hospital charity care. Some commenters believed Worksheet S-10 should be revised to better reflect the actual cost of caring for Medicaid patients incurred by hospitals (that is, net of Medicaid DSH payments and other supplemental funding).

Response: We appreciate commenters' suggestions for revisions and/or modifications to Worksheet S-10. We will consider the concerns raised by commenters as part of future cost report clarifications, and will make modifications as necessary, to further improve and refine the information that is reported on Worksheet S-10 to support collection of the information necessary to implement section 1886(r)(2) of the Act. With regard to the comments requesting that payment shortfalls from Medicaid and state and local indigent care programs be included in uncompensated care cost calculations, we recognize commenters' concerns but continue to believe there are compelling arguments for excluding such shortfalls from the definition of uncompensated care. For example, and as noted in past rulemaking, several key stakeholders, including MedPAC, do not consider Medicaid shortfalls in their definition of uncompensated care. Furthermore, we continue to believe that it is most consistent with section 1886(r)(2) of the Act for Medicare uncompensated care payments to target hospitals that incur a disproportionate share of uncompensated care for patients with no insurance coverage. In more practical terms, we also note that even if we agreed that it would be appropriate to adjust the definition of

uncompensated care to include Medicaid shortfalls, this would not be a feasible option at this time due to computational limitations. Specifically, computing such shortfalls is operationally problematic because Medicaid pays hospitals a single DSH payment that in part covers the hospital's costs in providing care to the uninsured and in part covers estimates of the Medicaid "shortfalls." Therefore, it is not clear how CMS would determine how much of the "shortfall" is left after the Medicaid DSH payment is made. In addition, in some States, hospitals return a portion of their Medicaid revenues to the State via provider taxes and receive supplemental payments in return (along with the federal match), making the computation of "shortfalls" even more complex. Accordingly, after consideration of the comments received, and for the reasons discussed in the proposed rule and previously in this final rule, we are finalizing our proposal to continue to define uncompensated care costs 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).

Comment: Commenters also suggested that CMS include all patient care costs when calculating the cost to charge ratio used in Worksheet S-10 including costs associated with training medical residents, supporting physician and professional services and paying provider taxes, so as to more accurately determine uncompensated care costs for purposes of the Worksheet S-10. Specifically, a commenter stated that the cost-to-charge ratio in line 1 does not include medical education costs and recommended that CMS include these costs, which they maintain can be derived from Worksheet B, column 24, line 118

Response: As we have consistently stated in past final rules (84 FR 42378) in response to similar comments, we believe that the purpose of uncompensated care payments is to provide additional payment to hospitals for treating the uninsured, not for other costs incurred, including

costs associated with supporting and training physicians and other professionals or paying provider taxes associated with Medicaid, as commenters have suggested. In addition, because the CCR on Line 1 of Worksheet S-10 is obtained from Worksheet C, Part I, and is also used in other IPPS rate setting contexts (such as high-cost outliers and the calculation of the MS–DRG relative weights) from which it is appropriate to exclude the costs associated with supporting physician and professional services and GME, we remain hesitant to adjust CCRs in the narrower context of calculating uncompensated care costs. Therefore, we continue to believe that it is not appropriate to modify the calculation of the CCR on Line 1 of Worksheet S-10 to include any additional costs in the numerator of the CCR calculation.

Comment: A few commenters requested that implicit price concessions be included in the definition of uncompensated care. Specifically, commenters expressed concern that without clear reporting instructions, implicit price concessions may no longer be included in Worksheet S-10 as bad debt and requested that CMS clarify that they should be considered as bad debt and must be included on the Medicare cost report. A commenter also expressed concern that CMS's requirement that hospitals write off Medicare beneficiary accounts that meet a hospital's financial assistance policy to bad debt, rather than charity care, causes their uncompensated care payments to be reduced because these implicit price concessions are multiplied by the hospital's cost to charge ratio (CCR), which is inconsistent with general accounting practices and could cause distortion in the distribution of uncompensated care payments.

Response: We appreciate commenters' input in regard to CMS's proposed policy on implicit price concessions and bad debt and the implications for Worksheet S-10 reporting. For further discussion and clarification on this topic, we refer readers to the bad debt section in this final rule. We note that the final bad debt policy related to implicit price concessions that we are

adopting this final rule will be prospectively effective for cost reporting periods beginning on or after October 1, 2020.

Comment: Some commenters raised the use of presumptive eligibility tools in the determination of patient charity care, arguing that such tools offer an efficient and accurate way to determine uncompensated care costs. Specifically, commenters stated that the issue is that the MACs disallow charity care granted using such tools, adding that CMS should clarify that providers may indeed utilize presumptive eligibility as indicator of charity care and encouraged the agency to expedite updating the Provider Reimbursement Manual to clarify this issue.

Response: We appreciate commenters' input on this issue. With regard to the comments regarding the use of presumptive eligibility tools to determine charity care, we note that CMS does not set charity care criteria policy for hospitals, and within reason, hospitals can establish their own criteria for what constitutes charity care in their charity care and/or financial assistance policies. We refer the reader to the section IX.C (Revisions of Medicare Bad Debt Policy)of this preamble for related discussion of presumptive eligibility tools. We note that the forthcoming Paper Reduction Act (PRA) package for Form CMS–2552–10 (OMB Control Number 0938–0050, expiration date March 31, 2022) offers an additional opportunity for hospitals and other stakeholders to comment on the cost reporting instructions.

Comment: A few commenters requested additional information from CMS on how payments furnished by Congress, as well as payments made by the Health Resources and Services Administration (HRSA) for uninsured COVID-19 patients will be treated, pointing out that such payments may not necessarily offset uncompensated care, but, rather, were intended to cover the costs of responding to the COVID-19 PHE. To this end, another commenter noted funding provided by the Department of Health and Human Services (HHS) "in the general distribution,

high-impact distribution, safety net distribution, and other allocations funded via the CARES Act would not be an offset specifically to uncompensated care."

Response: We recognize commenters' concerns regarding the unique situation posed by the COVID-19 PHE in the reporting of uncompensated care costs. We will consider these concerns as appropriate in developing future reporting guidance. General information on the CARES Act Provider Relief Fund is available at: https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/general-information/index.html. Information regarding HRSA COVID-19 and information on the HRSA Uninsured Program is available at: https://coviduninsuredclaim.linkhealth.com/. We note that a term and condition of the HRSA Uninsured Program is the following "The Recipient will not include costs for which Payment was received in cost reports or otherwise seek uncompensated care reimbursement through federal or state programs for items or services for which Payment was received."

The following comments relate to the Worksheet S-10 instructions:

Comment: In regard to Worksheet S-10 instructions and guidance, several commenters commended CMS for its refinements to Worksheet S-10 in November 2016 (Transmittal 10) and for its continued efforts to improve the accuracy of the reported data, indicating that the instructions have improved. However, many commenters still requested that CMS clarify instructions to the Worksheet S-10 in areas where the treatment of uncompensated care costs (charity care and bad debt) is not immediately clear based on the revised instructions. A commenter suggested that CMS should engage MACs and hospitals prior to the release of substantial revisions to cost report instructions, which, according to the commenter, would promote dialogue on best reporting practices; similarly, another commenter suggested that CMS

conduct additional outreach for stakeholder feedback and education before making revisions to Worksheet S-10 instructions.

One common issue raised by commenters was a request that CMS improve the instructions so that non-Medicare bad debt is not multiplied by the cost-to-charge ratio. According to a commenter, applying the cost to charge ratio to non-Medicare bad debt is not mathematically sound nor does it represent a hospital's true cost. Another commenter indicated that such practice is also inconsistent with the way non-reimbursable Medicare bad debt is treated. To address this, commenters suggested that CMS establish separate columns in Worksheet S-10 for insured and uninsured bad debt, where the column for insured bad debt is not multiplied by the CCR and the column for uninsured bad debt is multiplied by the CCR, as is currently done with charity care.

Another suggestion was that CMS insert two new columns before column 2 in the Worksheet S-10 to enable hospitals to separately report charges subject the CCR. According to the commenter, such a structure would be needed for lines 20 and 21 but not for lines 22 and 23; per the commenter's recommendation, CMS would be able to discontinue lines 24 and 25, given that those amounts would be obsolete under the commenter's recommended restructuring of the worksheet. Further, the commenter requested that CMS clarify whether the wording "total facility except physician and other professional services," in relation to charity care and bad debt write-offs is inclusive of acute inpatient, exempt inpatient, outpatient, and long-term care services. The commenter also sought clarification of the definition of "non-covered" charges related to days exceeding the length of stay limit and with respect to Medicare, Medicaid, Workers' Compensation/No Fault, and commercial plans with which the hospital has a contractual relationship, but is not allowed to pursue patient collections for losses (for example,

unpaid claims). In addition, the commenter sought clarification on whether a hospital is permitted to include such losses on Line 20, if it includes them in its financial assistance policy.

Finally, a commenter inquired if there were any templates under review for reporting charity care, uninsured discounts, and/or bad debt listings and, if so, the status of any such templates. The commenter also recommended that CMS should require the total bad debt listing to be submitted and reconciled with Worksheet S-10 line 26.

Response: We appreciate commenters' concerns regarding the need for clarification of the Worksheet S-10 instructions, as well as their suggestions for form revisions to improve provider reporting. We reiterate our commitment to continuing to work with stakeholders to address their concerns regarding Worksheet S-10 instructions and reporting through provider education and further refinement of the instructions as appropriate. As noted by some commenters, such continued efforts to refine the instructions and guidance have improved provider understanding of the Worksheet S-10. We also recognize that there are continuing opportunities to further improve the accuracy and consistency of the information that is reported on the Worksheet S-10, and to the extent that commenters have raised new questions and concerns regarding the reporting requirements, we will attempt to address them through future rulemaking and/or sub-regulatory guidance. However, we also continue to believe that the Worksheet S-10 instructions are sufficiently clear to allow hospitals to accurately complete Worksheet S-10. Regarding the comments requesting specific structural changes to Worksheet S-10 and/or further clarification of the reporting instructions, we note that these comments fall outside the scope of this final rule. We therefore refer commenters to the forthcoming Paper Reduction Act (PRA) package for the Worksheet S-10, which will include a public comment

period and will be the appropriate forum to raise specific questions about or suggestions for modifications to Worksheet S-10, including the reporting instructions.

Additionally, we refer commenters to the updated instructions for Worksheet S-10 that were issued in November 2016 through Transmittal 10, as well as those issued in September 2017 through Transmittal 11, in which we specifically clarified the definitions of and the instructions for reporting uncompensated care, non-Medicare bad debt, non-reimbursed Medicare bad debt, charity care, and modified the calculations relative to uncompensated care costs as well as added edits to improve the integrity of the data reported on Worksheet S-10.

For commenters' reference, additional materials regarding clarifications to the Worksheet S-10 instructions are contained in the MLN article titled "Updates to Medicare's Cost Report Worksheet S-10 to Capture Uncompensated Care Data", available at https://www.cms.gov/Outreach-and- Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/ SE17031.pdf as well as the Worksheet S-10 Q&As on the CMS DSH website in the download section, available at: https://www.cms.gov/Medicare/ Medicare-Fee-for-Service-Payment/ AcuteInpatientPPS/Downloads/ Worksheet-S-10-UCC-QandAs.pdf.

(d) 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 that were discussed in the IPPS/LTCH PPS proposed rule 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. Our 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 the year are included in the new combined hospital's cost report (83 FR 41427), we proposed to modify the annualization policy that was finalized in FY 2019 with respect to merged hospitals.

We noted 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 proposed to use for the Factor 3 calculation), we stated that 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 later in this section, we proposed 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 the 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, to more accurately estimate UCC for the hospitals involved in a merger when the merger effective date occurs partway through the surviving hospital's cost reporting period, we proposed not to annualize the acquired hospital's data. Further, we proposed 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 proposed 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 would 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 would 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, we assumed the merger effective date was 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 explained our belief that 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 proposed to continue to treat hospitals that merge after the development of the final rule for the applicable fiscal year 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 proposed to treat newly merged hospitals in a similar manner to 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 proposed that the data from the newly merged hospital's cost report would be annualized for purposes of the Factor 3 calculation. We noted that we were 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 prorated, if applicable. We referred readers 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 proposed 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, the eligibility of 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.

Comment: A few commenters supported CMS's policy proposal for combining uncompensated care costs data in the case of mergers by using a multiplier to adjust the acquired hospital's data. A commenter also supported the proposed policy regarding the treatment of mergers that happen after the final rule is issued. Another commenter, who expressed support for the annualization of uncompensated care costs from cost reports containing less than 12 months of data for the purpose of calculating Factor 3, also supported CMS's proposal to annualize the surviving newly merged hospital's cost report data for purposes of determining that hospital's proportion of uncompensated care.

Response: We appreciate the support for our proposal to apply a multiplier to the acquired hospital's unannualized uncompensated care cost data to determine the final portion of the acquired hospital's uncompensated care costs that should be added to the uncompensated care costs of the surviving hospital for purposes of determining Factor 3. We also appreciate support for the proposal to treat hospitals that merge after the final rule has been issued as new hospitals. Additionally, we appreciate the support for our policy of annualizing the data from cost reports that do not include 12 months of data, including our proposal to annualize the data for surviving newly merged hospitals if their cost reporting period does not equal 12 months.

- *Annualization and Long Cost Reports*

We proposed 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 modified merger policy previously discussed. In addition, we proposed 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 proposed 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 explained that 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.

Comment: Some commenters supported the continuation of annualization and the proposed modification to the long cost report policy.

Response: We appreciate the support for our proposals. We are finalizing as proposed.

- *New Hospital for Purposes of Factor 3*

We proposed 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 proposed 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.

Comment: Commenters supported this proposal for continuing the new hospital policy.

Response: We thank the commenters for their support. We are finalizing as proposed, without modification.

- *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 the 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 the 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. We noted that an o 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, provides an overview of the instructions and requirements for reporting on the Worksheet S-10 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, we also noted that 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 and solicited comment on this issue to assist future rulemaking. We also noted 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 proposed to continue the policy first adopted for the FY 2018 rulemaking regarding the low-income patient proxy. Specifically, for FY 2021 we proposed 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 explained that 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 the 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.

We refer the reader to the previous section for a discussion regarding comments related to IHS and Tribal hospitals. We are finalizing the above methodology for IHS and Tribal hospitals for FY 2021 as proposed without modification.

- *Puerto Rico Hospitals*

In the FY 2021 IPPS/LTCH PPS proposed rule, we explained that we had considered calculating the Factor 3 amounts for Puerto Rico hospitals for FY 2021 using the same methodology we proposed 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 proposed 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 proposed 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 proposed 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).

We refer the reader to the previous section for a discussion regarding comments related to Puerto Rico hospitals. We are finalizing the above methodology for Puerto Rico hospitals for FY 2021 as proposed without modification.

- *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 proposed to modify the potentially aberrant UCC trim methodology when it is applied to all-inclusive rate providers. Specifically, we proposed 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 the proposed rule, we identified a few AIRPs that had 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. As we explained in the proposed rule, 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.

Comment: A commenters supported this proposal related to AIRPs.

Response: We thank the commenter for their support. ● *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 proposed 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.

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. (As explained in the proposed rule, 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 the proposed rule, the statewide average CCR was applied to 12 hospitals, of

which 4 hospitals had FY 2017 Worksheet S–10 data. (For this final rule, the statewide average CCR was applied to 13 hospitals, of which 3 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.

We proposed that after completing the described previously steps, we would re-calculate the hospital's uncompensated care costs (Line 30) using the trimmed CCR (the statewide average CCR (urban or rural, as applicable)).

Comment: In relation to the proposed CCR trim methodology a commenter requested that CMS reconsider its policy of applying the state-wide average CCR for providers with a CCR above the proposed ceiling. The commenter suggested an alternative approach of using the hospital's previous CCR or an average of two or three years CCRs to reflect the provider's actual experience. Another commenter supported CMS's proposed policy of excluding All-Inclusive Rate Providers (AIRPs) from the CCR trim methodology and agreed with CMS's proposed approach of assessing whether the amount of uncompensated care resulting from the product of the AIRP-reported CCR and uncompensated care charges is greater than 50 percent of total operating costs; in such cases, CMS proposed to use the CCR from the 2015 Worksheet S-10, which, according to a commenter, the agency has already vetted.

Response: We appreciate the comments regarding the proposed CCR trim methodology. We believe that the suggested alternative approaches to the use of the statewide average CCR for providers with a CCR above the CCR "ceiling", including using a hospital's previous CCR or an average of multiple CCRs, may not provide a solution as some providers may still have high CCRs in the past fiscal years. Further, we note that the proposed CCR trim methodology is not only similar to the CCR trim methodology policy that has been used for

purposes of determining uncompensated care payments since FY 2018, but is also consistent with the approach used in the outlier payment methodology under § 412.84(h)(3)(ii), which states that the Medicare contractor may use a statewide average CCR for hospitals whose operating or capital CCR is in excess of 3 standard deviations above the corresponding national geometric mean.

- *Uncompensated Care Data Trim Methodology*

In the proposed rule, we noted that after applying the CCR trim methodology, there are rare situations where a hospital has potentially aberrant data that are unrelated to its CCR. Therefore, we proposed 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 proposed 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 proposed 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 explained our belief that 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 stated that we no longer believe it is necessary to apply the trim methodology for these audited hospitals. Accordingly, we proposed to 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 proposed to continue to apply the trim methodology as previously described.

Comment: A few commenters expressed support for the proposal to substitute extremely high uncompensated care costs with information from FY 2018 cost reports and supported the agency's proposed modification to the uncompensated care data trim methodology to exempt hospitals for which uncompensated care values have been audited from the application of the uncompensated care cost adjustment.

Response: We appreciate the comments regarding our proposed policy for trimming uncompensated care costs that are an extremely high ratio of a hospital's total operating costs for the same year. We believe the proposed approach balances our desire to exclude potentially aberrant data with our concern regarding inappropriately reducing FY 2021 uncompensated care payments to a hospital that may have a legitimately high ratio as determined through an audit of their Worksheet S-10 data.

- *Summary of Proposed Methodology*

In summary, for FY 2021, we proposed 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 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 proposed to amend the regulation at § 412.106 by adding a new paragraph (g)(1)(iii)(C)(*7*) to reflect the methodology for computing Factor 3 for FY 2021. We also proposed 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.

Comment: Some commenters urged CMS to consider a five to ten percent stop-loss policy across all hospitals' uncompensated care payments, so as to help mitigate and minimize hospital uncompensated care payment fluctuations across years.

Response: As discussed in last year's final rule (84 FR 42366) and prior rulemaking, section 1886(r) does not provide CMS with authority to implement a stop-loss policy. Rather, section 1886(r)(2)(C) requires that we determine Factor 3 for each hospital based upon the ratio of the amount of uncompensated care furnished by the hospital compared to the uncompensated care furnished by all DSH-eligible hospitals, and there is no authority under section 1886(r) to adjust this amount. We note that the use of three years of data to determine Factor 3 for FY 2018 and FY 2019, as discussed in the FY 2020 IPPS/LTCH PPS final rule already provided a mechanism that had the effect of smoothing the transition from the use of low-income insured days to the use of Worksheet S-10 data. However, we will continue to monitor uncompensated care payments for payment fluctuations as we move forward with using only one year of Worksheet S-10 for future Factor 3 calculations.

Comment: A commenter recommended that CMS use the traditional payment reconciliation process to calculate final payments for uncompensated care costs pursuant to section 1886(r)(2) of the Act. The commenter did not object to CMS using prospective estimates, derived from the best data available, to calculate interim payments for uncompensated care costs. However, the commenter stated that interim payments should be subject to later reconciliation based on estimates derived from actual data from the Federal fiscal year. The commenter also noted that not all FY 2017 Worksheet S-10 cost reports were audited and that the use of this blend of audited and unaudited data would be arbitrary and consistent with the statutory requirements. This same commenter also expressed the need for meaningful engagement on

concerns raised in the rulemaking process, and stated that the preclusion of review provision leaves intact the agency's responsibilities, including the rulemaking requirements of the Administrative Procedure Act and the Medicare Act.

Response: Consistent with the position that we have taken in rulemaking for previous years, we continue to believe that applying our best estimates of the three factors used in the calculation of uncompensated care payments to determine payments prospectively is most conducive to administrative efficiency, finality, and predictability in payments (78 FR 50628; 79 FR 50010; 80 FR 49518; 81 FR 56949; 82 FR 38195; and 84 FR 42373). We believe that, in affording the Secretary the discretion to estimate the three factors used to determine uncompensated care payments and by including a prohibition against administrative and judicial review of those estimates in section 1886(r)(3) of the Act, Congress recognized the importance of finality and predictability under a prospective payment system. As a result, we do not agree with the commenter's suggestion that we should establish a process for reconciling our estimates of uncompensated care payments, which would be contrary to the notion of prospectivity. Furthermore, we note that this rulemaking has been conducted consistent with the requirements of the Administrative Procedure Act and Title XVIII of the Act. Under the Administrative Procedure Act, a proposed rule is required to include either the terms or substance of the proposed rule or a description of the subjects and issues involved. In this case, the FY 2021 IPPS/LTCH PPS proposed rule included a detailed discussion of our proposed methodology for calculating Factor 3 and the data that would be used. We made public the best data available at the time of the proposed rule, in order to allow hospitals to understand the anticipated impact of the proposed methodology and submit comments, and we have considered those comments in determining our final policies for FY 2021.

After consideration of the public comments we received, and for the reasons discussed in the proposed rule and in this final rule,

for FY 2021, we are finalizing the following methodology to compute Factor 3 for each hospital by—

Step 1: Selecting 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: 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 adjusted and/or annualized uncompensated care costs for hospitals that merged using the merger policy, discussed earlier.

Step 4: Calculating 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: Calculating 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 also are finalizing without modification the other proposals related to the Factor 3 methodology that are discussed in this section.

For this FY 2021 IPPS/LTCH PPS final rule, we are finalizing a HCRIS cutoff of June 30, 2020, for purposes of calculating Factor 3, except in rare situations where report upload discrepancies by CMS or the MACs have been corrected, as appropriate. We are also finalizing our proposal to amend the regulations at § 412.106(g)(1)(iii)(C) by adding new paragraphs (7) and (8) to reflect the methodology for computing Factor 3 for FY 2021 and for subsequent fiscal years. In brief, the methodology adopted in this final rule for purposes of determining Factor 3 would apply for FY 2022 and subsequent years, using Worksheet S-10 data from the most recent cost reporting year for which audits have been conducted.

(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 proposed 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 proposed 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 proposed 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 would not change how the total uncompensated care payment amount will be reconciled at cost report settlement.

Comments: A few commenters recognized the effort CMS has taken in addressing uncompensated care overpayments. These commenters expressed support for the proposal to provide an option for hospitals to submit a request to their MAC for a lower interim uncompensated care payment. The commenters noted that the policy would mitigate discharge growth discrepancies that could lead to an overestimate of the per-discharge amount of interim uncompensated payments, which could cause unstable cash flows for hospitals.

In contrast, a commenter stated that it seemed unlikely hospitals would want to request lower or zero per-claim uncompensated care payments because of inherent incentives to maximize their cash flow. The commenter also noted that the current claims average does not consider the growth in Medicare eligibility since 2019 due to the aging of baby boomers. This lack of consideration, according to the commenter, results in the risk of overpayments for uncompensated care and unstable cash flows for hospitals and MA plans. To minimize this risk, the commenter suggested a growth factor, based on the CBO estimate of 64 million Part A fee-for-service beneficiaries in 2021 compared to the 61 million in 2019, be applied to the three-year claims average (that is, a growth factor of 1.05 (64/61)).

The commenter also expressed concern that exorbitant amounts in per-claim uncompensated care payments could result in surprise balance billing if MA beneficiaries use an out-of-network provider, where coinsurance payments could range from 20 percent to 40

percent. To avoid this situation, the commenter recommended that CMS place a cap on per-discharge uncompensated care payments "within the range of $6,232 - $12,464, which represents a range of one to two standard deviations of the Estimated Per Claim Amounts for all qualifying hospitals."

Response: We thank commenters for their thoughtful suggestions regarding our proposal to allow hospitals the opportunity to voluntarily request a decrease to their per-claim uncompensated care payments. We are finalizing the policy as proposed without modification, because we believe the policy may facilitate greater payment predictability throughout the year and limit recoupment of overpayments as part of cost report settlement. We will consider commenters' input and suggestions regarding this policy in considering any potential modifications or refinements to this policy in future rulemaking.

(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 this final rule, we will publish on the CMS website a table listing Factor 3 for all hospitals that we estimate will receive empirically justified Medicare DSH payments in FY 2021 (that is, those hospitals that will 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 this final rule, the FY 2018 SSI ratios were available. Accordingly, 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 had 60 days from the date of public display of the FY 2021 IPPS/LTCH PPS proposed rule to review the table and supplemental data file published on the CMS website in conjunction with the 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). We stated that comments that are specific to the information included in the table and supplemental data file could be submitted to the CMS inbox at Section3133DSH@cms.hhs.gov. We indicated we would address these comments 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 2020 IPPS/LTCH PPS final rule.

For FY 2021, we proposed 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. We stated that any changes to Factor 3 would be posted on the CMS website prior to October 1, 2020. We acknowledged that this is less time compared to previous years. However, we noted that there is only a limited amount of time for CMS to review the information submitted by the hospitals and to implement the finalized policies before the start of the Federal fiscal year. We explained our belief that

hospitals would have sufficient opportunity during the comment period for the proposed rule to provide information about recent and/or pending mergers and/or to report upload discrepancies. We further explained that we expected to use data from the March 2020 HCRIS extract for the FY 2021 final rule, which contributed to our increased confidence that hospitals would be able to comment on mergers and report any upload discrepancies during the comment period following the final rule. However, we also noted that we might consider using more recent data that may become available after March 2020, but before the final rule for purpose of calculating the final Factor 3s for purposes of the FY 2021 IPPS/LTCH PPS final rule. We stated that 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 noted that 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 for the proposed rule should provide sufficient opportunity for hospitals to notify CMS regarding pending mergers and/or to report upload discrepancies.

Comment: Several commenters expressed concern related to the proposed 15-business day deadline to submit comments on the accuracy of the supplemental data files after the FY 2021 IPPS/LTCH final rule is posted. A few commenters requested at least 30 days to review the files in order to ensure the accuracy of the data. A commenter indicated that the additional time to review would be especially important in light of the COVID-19 PHE. The commenter also argued that CMS has consistently delayed the release of the proposed rules and that the 15-business day period allocated for review after the final rule is not sufficient. Related to this, a

commenter requested that CMS release the proposed rule for FY 2022 and subsequent proposed rules earlier.

A commenter also recommended that CMS provide at least a 14-day period for hospitals to submit corrections to their uncompensated care data arising from MAC and /or CMS mishandling of cost report data either related to a Worksheet S-10 audit and/or any other report upload issue, adding that such a policy would be conceptually consistent with the 14-day period to submit corrections in the merger listing.

Response: We thank the commenters for providing feedback on our proposed 15-business day timeframe to review and submit comments regarding the public use files published in conjunction with this FY 2021 IPPS/LTCH final rule. We are finalizing the proposal as we continue to believe a 15-business day review period is sufficient. Hospitals do not enter into mergers without advanced planning. A hospital can inform CMS during the comment period regarding merger activity not reflected in supplemental file published in conjunction with the proposed rule. This is true irrespective of a PHE. We note also that the historical FY 2017 cost reports are publically available on a quarterly basis on the CMS website for analysis and review of cost report data, which is another opportunity to review cost report data, separate from the supplemental data file published with this final rule..

In regard to the comment requesting a 14-day period to address MAC and/or CMS mishandling of data, we note that we are finalizing our proposal to afford hospitals 15 business days from the public display of the FY 2021 IPPS/LTCH PPS final rule to submit comments on the accuracy of the supplemental data file, including with respect to mergers and/or report upload discrepancies. As noted in the FY 2021 IPPS/LTCH PPS proposed rule, the CMS inbox is not

intended for Worksheet S-10 audit process related emails or inquiries, which should be directed to the respective MAC.

As noted in the FY 2021 IPPS/LTCH PPS proposed rule, we intend to revisit the necessity of this additional review period following the publication of the final rule. As discussed in the proposed rule, under usual circumstances the 60-day comment period on the supplemental data file issued with the proposed rule should be sufficient time to provide information about mergers and/or to report upload discrepancies. We note that the December HCRIS extract is usually available in January; thus, stakeholders would be able to perform initial review of that data when it becomes available to confirm their report was properly processed. Therefore, this review could occur before the comment period for the proposed rule. We will take commenters' suggestions into consideration as part of any future rulemaking on the issue of whether a review period following the final rule continues to be needed.

Comment: A commenter identified a discrepancy in the FY 2021 proposed rule's supplemental tables, in which a provider was misclassified as a "new hospital" despite having received prior DSH payments. The commenter encouraged CMS to reevaluate the status of the misclassified provider and update the hospital's status accordingly in the public use files in the final rule.

Another commenter pointed out that in the FY 2021 proposed rule's supplemental data file, their hospital is projected to be ineligible for DSH because the data used in the proposed rule was based on a cost reporting year pre-Medicaid expansion. The commenter indicated that while Medicare allows providers to retrospectively settle DSH and uncompensated care payments on their Medicare Cost Reports, MA plans currently do not, resulting in a significant under-reimbursement in FY 2021. According to the commenter, they can only receive DSH payments

from MA plans if the uncompensated care rate is loaded into their specific IPPS Pricer File. The commenter requested that CMS consider updating their DSH data to reflect the As Filed 2019 Medicare cost report in the FY 2021 final rule public use file.

Response: We appreciate the commenters' diligence in checking that their own reports and data were properly processed. As appropriate, we have accounted for the inaccuracies identified by commenters in the development of the final rule's DSH supplemental data file published in conjunction with this FY 2021 IPPS/LTCH final rule, and we will continue to pay diligent attention to any data issues and work internally and with our contractors to resolve these issues in a timely manner.

In regard to the commenter's concern about the retrospective settlement of DSH uncompensated care payments on their cost report and the impact of any potential delay in establishing their interim DSH eligibility in relation to their contractual relationship with MA plans, we note that this issue is beyond the scope of this rulemaking.

H. 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 subsection (d) hospitals (that is, hospitals paid under the IPPS). In addition, IPPS payments for acquisition services associated with allogeneic hematopoietic stem cell transplants are currently