E. Payment Adjustment for Medicare Disproportionate Share Hospitals (DSHs) for FY 2022 (§ 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 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.

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 a 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 a 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. For the FY 2022 IPPS/LTCH PPS proposed rule, we proposed to determine eligibility for interim uncompensated care payments based on each hospital's estimated DSH status for the applicable fiscal year using the best available data, as discussed in section V.E. of the preamble of the proposed rule. In the proposed rule, we also referred readers to a discussion of the inpatient Provider Specific File in section II.A.4 of the Addendum of the proposed rule (86 FR 25725). In the FY 2022 IPPS/LTCH PPS proposed rule

(86 FR 25443 and 25444), we discussed our specific policies regarding eligibility to receive empirically justified Medicare DSH payments and uncompensated care payments for FY 2022 with respect to the following hospitals:

- *Subsection (d) Puerto Rico hospitals* that are eligible for DSH payments also are eligible to receive empirically justified Medicare DSH payments and uncompensated care payments under the new payment methodology (78 FR 50623 and 79 FR 50006).

- *Maryland hospitals* are not eligible to receive empirically justified Medicare DSH payments and uncompensated care payments under the payment methodology of section 1886(r) of the Act because they are not paid under the IPPS. As discussed in the FY 2019 IPPS/LTCH PPS final rule (83 FR 41402 through 41403), CMS and the State have entered into an agreement to govern payments to Maryland hospitals under a new payment model, the Maryland Total Cost of Care (TCOC) Model, which began on January 1, 2019. Under the Maryland TCOC Model, Maryland hospitals will not be paid under the IPPS in FY 2022, 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 proposed to 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 best available data). 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 (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 participate 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. In the FY 2022 IPPS/LTCH PPS proposed rule, we referred readers to the interim final rule with request for comments that appeared in the November 6, 2020 **Federal Register** for a discussion of the Model (85 FR 71167 through 71173). In that interim final rule, we extended the Model's Performance Year 5 to September 30, 2021. In a subsequent final rule that appeared in the May 3, 2021 **Federal Register** (86 FR 23496), we further extended the Model for an additional three performance years. The Model's Performance Year 8 will end on December 31, 2024.

- *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. The Consolidated Appropriations Act of 2020 (Pub. L. 116-260) amended section 410A of Pub. L. 108–173 to extend the Rural Community Hospital Demonstration Program for an additional 5-year period. At the time of issuance of the proposed rule, we believed 27 hospitals might participate in the demonstration program at the start of FY 2022. At the time of development of this final rule, there are 26 hospitals that will be participating in the demonstration program in FY 2022. Under the payment methodology that applies during the third 5-year extension period for 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.

We received no comments on our proposal to continue the policy of using the best available data regarding a hospital's estimated DSH status for purposes of determining eligibility for interim uncompensated care payments for FY 2022. Therefore, we are finalizing as proposed without modifications. Our final determination of a hospital's eligibility for uncompensated care payments will continue to be based on the hospital's actual DSH status at cost report settlement for that payment year.

We received public comments that were outside the scope of this proposed rule. Specifically, commenters expressed concerns related to Section 340B eligibility. Because we consider these public comments to be outside the scope of the proposed rule, we are not addressing them in this final rule.

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 the Medicare Administrative Contractors (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 2021, and the policies we are finalizing for FY 2022.

a. Calculation of Factor 1 for FY 2022

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.

In the FY 2022 IPPS/LTCH PPS proposed rule (86 FR 25444 through 25447), in order to determine Factor 1 in the uncompensated care payment formula for FY 2022, 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, we proposed that these estimates will not be revised or updated subsequent to the publication of our final projections in this FY 2022 IPPS/LTCH PPS final rule.

Therefore, in order to determine the two elements of proposed Factor 1 for FY 2022 (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 (OACT) 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 OACT'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 2019 through FY 2022 are discussed in the table titled "Factors Applied for FY 2019 through FY 2022 to Estimate Medicare DSH Expenditures Using FY 2018 Baseline."

For purposes of calculating Factor 1 and modeling the impact of the FY 2022 IPPS/LTCH PPS proposed rule, we used the Office of the Actuary's January 2021 Medicare DSH estimates, which were based on data from the September 2020 update of the Medicare Hospital Cost Report Information System (HCRIS) and the FY 2021 IPPS/LTCH PPS final rule IPPS Impact File, published in conjunction with the publication of the FY 2021 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 January 2021 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 January 2021 Medicare DSH estimates. The 27 hospitals that were anticipated to participate in the Rural Community Hospital Demonstration Program in FY 2022 were also excluded from these estimates, because under the payment methodology that applies during the third 5-year 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 January 2021 estimate of Medicare DSH payments for FY 2022 without regard to the application of section 1886(r)(1) of the Act, was approximately $14.098 billion. Therefore, also based on the January 2021 estimate, the estimate of empirically justified Medicare DSH payments for FY 2022, with the application of section 1886(r)(1) of the Act, was approximately $3.524 billion (or 25 percent of the total amount of estimated Medicare DSH payments for FY 2022). Under § 412.106(g)(1)(i) of the regulations, Factor 1 is the difference between these two OACT estimates. Therefore, in the proposed rule, we proposed that Factor 1 for FY 2022 would be $ 10,573,368,841.28, which is equal to 75 percent of the total amount of estimated Medicare DSH payments for FY 2021 ($14,097,825,121.71 minus $3,524,456,280.43). In the FY 2022 IPPS/LTCH PPS proposed rule, 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 this FY 2022 IPPS/LTCH PPS final rule.

As we noted in the FY 2022 IPPS/LTCH PPS proposed rule, the Factor 1 estimates for proposed rules are generally consistent with the economic assumptions and actuarial analysis used to develop the President's Budget estimates under current law, and the Factor 1 estimates for final rules are generally consistent with those used for the Midsession Review of the

President's Budget. As we have in the past, for additional information on the development of the President's Budget, we refer readers to the Office of Management and Budget website at: https://www.whitehouse.gov/omb/budget. Consistent with historical practice, we indicated that we expected the Midsession Review would have updated economic assumptions and actuarial analysis, which would be used for the development of Factor 1 estimates in the final rule. At the time of developing this final rule, the Midsession Review was not yet available, therefore the estimates in this final rule are generally consistent with the economic assumptions and actuarial analysis used to develop the forthcoming Medicare Trustees Report.

For a general overview of the principal steps involved in projecting future inpatient costs and utilization, we refer readers to 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?redirect=/reportstrustfunds/ under "Downloads." We note that the annual reports of the Medicare Boards of Trustees to Congress represent the Federal Government's official evaluation of the financial status of the Medicare Program. The actuarial projections contained in these reports are based on numerous assumptions regarding future trends in program enrollment, utilization and costs of health care services covered by Medicare, as well as other factors affecting program expenditures. In addition, although the methods used to estimate future costs based on these assumptions are complex, they are subject to periodic review by independent experts to ensure their validity and reasonableness.

We also refer readers to the 2018 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 and the data behind the assumptions be made public. Commenters requested that this information be provided in advance of the publication of the final rule and in the IPPS proposed rule each year going forward, in order that the data be available to replicate CMS' DSH calculation and comment sufficiently in future years. Similarly, another commenter requested that CMS provide hospitals and other stakeholders with a supplementary table and additional commentary on the year-to-year changes from the FY 2021 final rule to the FY 2022 proposed rule for the variables that comprise the "Other" factor. The commenter requested that CMS provide this information and allow for a brief supplemental comment period prior to finalizing the FY 2022 rule. The commenter stated that if CMS is unable to provide additional information in such a manner, then it should use the "Other" factor from the FY 2021 final rule for the FY 2022 final rule. Another commenter suggested that the methodology and assumptions in projecting DSH costs be reviewed by independent experts.

Additionally, 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 2022 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 comments referencing 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 2022 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. Accordingly, we believe commenters were able to meaningfully comment on our proposed estimate of Factor 1.

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 forthcoming "2021 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds" which will be made 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.

For a general overview of the principal steps involved in projecting future inpatient costs and utilization, we refer readers to the forthcoming 2021 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 2022 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 the effect of 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 2022, which also incorporates the estimated impact of the COVID-19 pandemic.

Comment: Many commenters requested that CMS calculate estimated DSH payments for purposes of Factor 1 without adjusting for the impact of the COVID-19 PHE, which the commenters believed would align with other CMS proposals regarding COVID-19 PHE data (for example, IPPS and LTCH ratesetting proposal to use FY 2019 claims data). Many other commenters urged CMS to consider freezing data prior to the PHE for purposes of the Factor 1 methodology. Commenters stated that excluding PHE impacts from Factor 1 methodology

would allow more time to evaluate national Medicare uncompensated care funding and the ongoing impacts of the COVID-19 pandemic on beneficiaries and hospitals providing care.

Some commenters requested that CMS revisit the estimate for Factor 1 and provide greater transparency regarding its calculations, as they disagree with CMS' proposed 7.1% decrease from FY 2021. For example, according to a commenter, the September 2020 extract of HCRIS cost report files used in OACT's Factor 1 methodology for purposes of the proposed rule reflected providers that had minimal COVID-19 data (that is, March 2020 and earlier data), and this commenter requested that CMS revisit the estimates and provide greater transparency. Some commenters believed that CMS should work to mitigate the effect of the pandemic and associated anomalies in FY 2020 and 2021 cost report data that will have an adverse on uncompensated care payments in future years.

Many commenters asserted that there was a much higher Medicaid enrollment in 2020-2021 during the pandemic than CMS estimated for purposes of Factor 1. A commenter referred to a New York Times article from June 21, 2021, which indicated that nearly 10 million Americans enrolled in Medicaid and CHIP during the pandemic. This same commenter also disagreed with OACT's assumption of lower utilization by newly eligible Medicaid enrollees, and the commenter believed that lower utilization was caused by patients' reluctance to seek care and instead opting to delay care and elective procedures during the PHE. The commenter urged CMS to be transparent in how the "Other" factor was determined and share the data behind its assumptions.

Another commenter cited survey data from the Kaiser Family Foundation that show a 7.7 million (or 10.8%) increase in Medicaid/CHIP enrollment from February 2020 to November 2020. Further, they noted that the 0.9 percentage point increase in the estimated increase in Medicaid enrollment for FY 2021 (FY 2021 Final Rule, 0.3%, FY 2022 Proposed Rule, 1.2%) does not explain the reduction in the estimate of the "other" factor for FY 2021—as such they can only infer there was a significant decrease in one or more of the "other" variables that

negated the increased estimate of Medicaid eligibility. To this end, commenters requested additional explanation for the proposed decrease to the "other" factor for FY 2021. Some commenters believed the 20% add-on to payments for COVID-10 discharges would have contributed to an increase in the "other" factor, rather than a decrease.

Many commenters questioned the proposed rule's estimate of the "Discharges" factor, in particular. Some commenters referenced a Kaufman Hall study, which showed that the year-to-date adjusted discharges were up 5.9% and the year-over-year and adjusted discharges were up 66.4% as of April 2021. A commenter also referred to national utilization data from Strata Decision Technology and stated that total inpatient admissions began to increase starting in February 2021, consistent with declines in COVID-19 inpatient volumes. The commenter stated that, although, FY 2021 volumes will remain lower than historic, pre-pandemic levels, the trends indicate that FY 2021 volumes will continue to increase. These comments urged CMS to carefully monitor changes in discharge volume when estimating Factor 1 for FY 2022. A commenter urged CMS to use a later update to the claims data consistent with the data that CMS otherwise uses to model IPPS impacts and set relative weights in a typical year. While some commenters believed that using the latest available data when finalizing Factor 1 might capture more of the increases in utilization that are anticipated for FY 2022, a commenter noted that the use of more recent data alone may not fully account for the increase in discharges during the second half of FY 2021. Another commenter noted that OACT's estimate of the "Discharges" factor was based on preliminary FY 2021 claims data, given the lack of time for "claims run out."

Additionally, commenters requested further explanation regarding the estimate of the "Other" factor used to estimate Medicare DSH payments, and in particular an analysis of the difference between total inpatient hospital discharges and IPPS discharges, along with the agency's quantitative analysis of the interplay between the various factors grouped together as "Other" factors impacting estimated DSH payments. Specifically, commenters requested that

OACT address the expected increase in IPPS discharges as a percentage of total inpatient hospital discharges in the latter half of FY 2021 and the impact of these FY 2021 data trends on the "Other" factors impacting estimated DSH Medicare payments for FY 2021. A commenter mentioned that, according to their own analysis, total inpatient discharges and IPPS discharges have changed in a similar manner. Another commenter stated that CMS has not adequately measured the impact of the shift away from direct patient care to telehealth care, in terms of hospital volumes and payments. A commenter also suggested that CMS use OACT's estimate of FY 2021 Medicare discharges from the FY 2021 Final Rule to estimate discharges for FY 2022 "Discharge" factor. Similarly, another commenter suggested that CMS use estimates of the "Other" factor variables from the FY 2021 Final Rule for FY 2022, because of the commenter's concerns with the transparency of the Factor 1 estimates in the FY 2022 proposed rule.

Other commenters believed that as vaccination rates increase and infection rates decline, people can be expected to begin addressing their deferred medical needs in the year ahead. As a result, these commenters indicated that the historical data used to estimate inpatient hospital utilization among Medicare and Medicaid-covered individuals understates the actual amount of inpatient care hospitals are likely to provide in the coming year.

Response: We thank the commenters for their input on impact projections, such as the impact on Medicaid enrollment from the COVID-19 PHE, and have taken into consideration the concerns commenters have raised in making our projection of Factor 1 for this FY 2022 IPPS/LTCH PPS final rule. 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 the "Other" factor are generally consistent with the updated Factor 2 calculation described in the next section. The updated estimates for the "Discharges" and "Case Mix" factors incorporate the latest estimates from OACT of the impact of COVID-19 on the Medicare program. We provide further details on the updated Factor 1 estimate and data

sources as part of the discussion of the final Factor 1 estimate for FY 2022 in this section of the rule.

Regarding the comments requesting further explanation of the difference between total inpatient hospital discharges and IPPS discharges, we note that the "Discharges" factor used to estimate Medicare DSH expenditures relates to IPPS discharges for DSH eligible hospitals. As discussed further in this section, the "Other" factor includes an estimate of the effect of the difference between total inpatient hospital discharges compared to discharges at IPPS hospitals (particularly those in DSH hospitals). Based on the data sources and modeling that are used for Factor 1, we do not break down this effect to the level that commenters are requesting additional information. In other words, we do not project each individual effect that is part of "Other" factor. We note that the OACT's FY 2022 estimate of 1.0038 for the "Other" factor is an increase relative to the FY 2021 estimate of 0.9662 for the "Other" factor.

Regarding the comments requesting that we exclude and/or mitigate the impacts of the pandemic when estimating Factor 1 for FY 2022, we note that the statute specifies that Factor 1 is based on the amount of disproportionate share payments that would otherwise be made to a subsection (d) hospital for the fiscal year. As discussed further in this section, OACT's estimates of Medicare DSH payments used in the development of Factor 1, reflect the estimated impact of the COVID-19 pandemic on DSH payments. We do not believe that excluding and/or mitigating the impact of the pandemic through adjustments to Factor 1 calculation would be consistent with the statute.

After consideration of the public comments we received, we are finalizing, as proposed, the methodology for calculating Factor 1 for FY 2022. We discuss the resulting Factor 1 amount for FY 2022 in this section. For this final rule, OACT used the most recently submitted Medicare cost report data from the March 31, 2021 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 2021 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 2021 OACT estimate for Medicare DSH payments for FY 2022, without regard to the application of section 1886(r)(1) of the Act, was approximately $13.985 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 2021 estimate, the estimate of empirically justified Medicare DSH payments for FY 2022, with the application of section 1886(r)(1) of the Act, was approximately $3.496 billion (or 25 percent of the total amount of estimated Medicare DSH payments for FY 2022). Under § 412.106(g)(1)(i) of the regulations, Factor 1 is the difference between these two OACT estimates. Therefore, the final Factor 1 for FY 2022 is $ 10,488,564,546.74, which is equal to 75 percent of the total amount of estimated Medicare DSH payments for FY 2022 ($13,984,752,728.99 minus $3,496,188,182.25). OACT's final estimates for FY 2022 began with a baseline of $13.882 billion in Medicare DSH expenditures for FY 2018. The following table shows the factors applied to update this baseline through the current estimate for FY 2022:

Factors Applied for FY 2019 through FY 2022 to Estimate Medicare DSH Expenditures Using FY 2018 Baseline						
FY	**Update**	**Discharges**	**Case-Mix**	**Other**	**Total**	**Estimated DSH Payment (in billions)***
2019	1.0185	0.97	1.009	1.0176	1.0144	14.082
2020	1.031	0.857	1.038	0.9912	0.9091	12.801
2021	1.029	1.013	1.029	0.9662	1.0364	13.267
2022	1.025	1.059	0.9675	1.00375	1.0541	13.985

*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 2019 and FY 2020 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 2021 is based on preliminary data. The discharge figure for FY 2022 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 FY 2020 to FY 2022 reflect the estimated impact of the COVID-19 pandemic. The case-mix column shows the estimated change in case-mix for IPPS hospitals. The case-mix figures for FY 2019 and FY 2020 are based on actual data adjusted by a completion factor. The case-mix figure for FY 2021 is based on preliminary data. The case-mix factor figures for FY 2020 and FY 2021 have been adjusted for the estimated impact of the COVID-19 pandemic. The FY 2022 increase is an estimate based on the recommendation of the 2010-2011 Medicare Technical Review Panel. The "Other" column shows the increase in other factors that contribute to the Medicare DSH estimates. These factors include the difference between the total inpatient hospital discharges and the IPPS discharges, and various adjustments to the payment rates that have been included over the years but are not reflected in the other columns (such as the change in rates for the 2-midnight stay policy 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 the information available at the time of development of this final rule, it is assumed that approximately 55 percent of all individuals who were potentially newly eligible Medicaid enrollees in 2018, 2019, and 2020 resided in States that had elected to expand Medicaid eligibility, and approximately 60 percent of all individuals who were potentially newly eligible Medicaid enrollees in 2021 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 due to the COVID-19 pandemic. In the proposed rule, we noted that, based on the most recent available data at that time, it was estimated that Medicaid enrollment increased by 2.9 percent in FY 2020 and would increase by an additional 1.2 percent in FY 2021. For this final rule, we have used updated assumptions of Medicaid enrollment. For a further

discussion, we refer readers to the OACT's Memorandum on Factor 1, available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.

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/MedicaidReport2017.pdf . We note that, in developing their estimates of the effect of Medicaid expansion on Medicare DSH expenditures, our actuaries have assumed that the new Medicaid enrollees are healthier than the average Medicaid recipient and, therefore, use fewer hospital services. Specifically, based on the most recent available data, OACT assumed per capita spending for Medicaid beneficiaries who enrolled due to the expansion to be 78 percent of the average per capita expenditures for a pre-expansion Medicaid beneficiary due to the better health of these beneficiaries. In the FY 2022 IPPS/LTCH PPS proposed rule (86 FR 25446), we noted that this is an updated assumption based on more recent data compared to the data available at the time of the FY 2021 IPPS/LTCH PPS final rule. This same assumption was used for the new Medicaid beneficiaries who enrolled in 2020 and thereafter 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	Productivity Adjustment	Documentation and Coding	Total Update Percentage
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	0.5	2.9
2022	2.7	0	-0.7	0.5	2.5

Note: All numbers are from the inpatient hospital updates for the applicable year, except for the FY 2022 percentages, which are based on the most recent forecast. We refer readers to section V.A. of the preamble of this final rule for a complete discussion of the changes in the inpatient hospital update for FY 2022, including a discussion of the productivity adjustment. We note that effective with FY 2022 and forward, CMS is changing the name of this adjustment to refer to it as the productivity adjustment rather than the MFP adjustment. We note that

the adjustment relies on the same underlying data and methodology. This new terminology is more consistent with the statutory language described in section 1886(b)(3)(B)(xi)(II) of the Act.

b. Calculation of Factor 2 for FY 2022

(1) Background

Section 1886(r)(2)(B) of the Act establishes Factor 2 in the calculation of the uncompensated care payment. Section 1886(r)(2)(B)(ii) of the Act provides that, for FY 2018 and subsequent fiscal years, the second factor is 1 minus the percent change in the percent of individuals who are uninsured, as determined by comparing the percent of individuals who were uninsured in 2013 (as estimated by the Secretary, based on data from the Census Bureau or other sources the Secretary determines appropriate, and certified by the Chief Actuary of CMS) and the percent of individuals who were uninsured in the most recent period for which data are available (as so estimated and certified), minus 0.2 percentage point for FYs 2018 and 2019. In FY 2020 and subsequent fiscal years, there is no longer a reduction. We note that, unlike section 1886(r)(2)(B)(i) of the Act, which governed the calculation of Factor 2 for FYs 2014, 2015, 2016, and 2017, section 1886(r)(2)(B)(ii) of the Act permits the use of a data source other than the CBO estimates to determine the percent change in the rate of uninsurance beginning in FY 2018. In addition, for FY 2018 and subsequent years, the statute does not require that the estimate of the percent of individuals who are uninsured be limited to individuals who are under 65 years of age.

As we discussed in the FY 2018 IPPS/LTCH PPS final rule (82 FR 38197), in our analysis of a potential data source for the rate of uninsurance for purposes of computing Factor 2 in FY 2018, we considered the following: (1) the extent to which the source accounted for the full U.S. population; (2) 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; (3) the extent to which the source utilized data from the Census Bureau; (4) the timeliness of the estimates; (5) the continuity of the estimates over time; (6) the accuracy of the

estimates; and (7) the availability of projections (including the availability of projections using an established estimation methodology that would allow for calculation of the rate of uninsurance for the applicable Federal fiscal year). As we explained in the FY 2018 IPPS/LTCH PPS final rule, these considerations are consistent with the statutory requirement that this estimate be based on data from the Census Bureau or other sources the Secretary determines appropriate and help to ensure the data source will provide reasonable estimates for the rate of uninsurance that are available in conjunction with the IPPS rulemaking cycle. We proposed to use a methodology similar to the one that was used in FY 2018 through FY 2021 to determine Factor 2 for FY 2022.

In the FY 2018 IPPS/LTCH PPS final rule (82 FR 38197 and 38198), we explained that we determined the source that, on balance, best meets all of these considerations is the uninsured estimates produced by 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. 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 U.S., plus a small (typically less than 0.2 percent of population) adjustment to reflect Census undercounts. For fiscal years 2014 through 2017, 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 U.S. 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 2019, 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 2019. 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 2019, OACT extrapolates from the 2009 CPS data through 2018 using data from the National Health Interview Survey (NHIS) and then, for 2019, OACT extrapolates using the American Community Survey (ACS). The NHIS is one of the major data collection programs of the National Center for Health Statistics (NCHS), which is part of the Centers for Disease Control and Prevention (CDC). For both the NHIS and ACS, the U.S. Census Bureau is the data collection agent. The results from these data sources 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. For further information regarding the ACS, we refer readers to the Census Bureau's website at: https://www.census.gov/programs-surveys/acs/ . In deriving the number of uninsured for the most recent release of the national health expenditure accounts, there were two concerns related to the data sources typically used. The NHIS underwent a redesign in 2019 and cautioned its users against comparing the year-over-year trend from 2018-2019 as a result. Also, the Census Bureau indicated that it experienced data collection issues for the 2019 CPS, which may have been affected by the COVID-19 pandemic,

and similarly cautioned its users to be aware of the potential impact on trend analysis between 2018 and 2019. Consequently, the ACS data were used for estimating 2019.

The next metrics needed to compute Factor 2 are projections of the rate of uninsurance in both CY 2021 and CY 2022. On an annual basis, OACT projects enrollment and spending trends for the coming 10-year period. Those projections use the latest NHEA historical data, available at the time of their construction. 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.

We refer readers to OACT's Memorandum on Certification of Rates of Uninsured prepared for the FY 2022 IPPS/LTCH proposed rule for further details on the methodology and assumptions that were used in the projection of the uninsurance rate.[762]

(2) Factor 2 for FY 2022

As discussed in the FY 2022 IPPS/LTCH PPS proposed rule (86 FR 25448 and 25449), using these data sources and the previously described methodologies, OACT estimated that the uninsured rate for the historical, baseline year of 2013 was 14 percent and for CYs 2021 and 2022 is 10.2 percent and 10.1 percent, respectively. The projected rates of uninsurance for CY 2021 and 2022 reflect the estimated impact of the COVID–19 pandemic. As required by section 1886(r)(2)(B)(ii) of the Act, the Chief Actuary of CMS has certified these estimates. However, for purposes of this final rule, we note that the OACT has added an addendum to the memo to reflect an updated estimate of projected rates of uninsurance for CY 2021 and 2022, as discussed in our responses to comments.

As with the CBO estimates on which we based Factor 2 for fiscal years before FY 2018, the NHEA estimates are for a calendar year. Under the approach originally adopted in the FY 2014 IPPS/LTCH PPS final rule, we have used a weighted average approach to project the rate of uninsurance for each fiscal year. We continue to believe that, in order to estimate the rate of uninsurance during a fiscal year 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 2022.

762 OACT Memorandum on Certification of Rates of Uninsured. March 12, 2021. Available at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInPatientPPS/dsh.html

As part of the development of the proposed Factor 2 for FY 2021, OACT certified the estimate of the rate of uninsurance for FY 2022 determined using this weighted average approach 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 2022. In particular, we noted that any potential impacts from the American Rescue Plan Act were not reflected in our estimates for the proposed rule, due to the timing for the development and publication of the FY 2022 IPPS/LTCH proposed rule.

In the proposed rule, we outlined the calculation of the proposed Factor 2 for FY 2022 as follows:

Percent of individuals without insurance for CY 2013: 14 percent.

Percent of individuals without insurance for CY 2021: 10.2 percent.

Percent of individuals without insurance for CY 2022: 10.1 percent.

Percent of individuals without insurance for FY 2022 (0.25 times 0.0102) + (0.75 times 0.0101): 10.1 percent.

1- |((0.101-0.14)/0.14)| = 1-0.2786 = 0.7214 (72.14 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 in order to determine Factor 2. Therefore, we proposed that Factor 2 for FY 2022 would be 72.14 percent.

The proposed FY 2022 uncompensated care amount was $ 10,573,368,841.28* 0.7214 = $7,627,628,282.10.

Proposed FY 2022 Uncompensated Care Amount	$ 7,627,628,282.10

We invited public comments on the proposed Factor 2 for FY 2022.

Comment: As with the comments received on proposed Factor 1, a majority of commenters discussed the proposed Factor 2 in the context of the COVID-19 PHE. Many 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. Many commenters urged OACT to update its projections of the rates of uninsurance to reflect changes in the rate of uninsurance due to the COVID-19 PHE, and in particular, current economic conditions. A commenter also recommended that the agency account for regulatory or legislative changes that could drive up uninsured rates as well as external factors, such as shifts in economic conditions.

Many commenters requested that CMS consider the shifts from commercial insurance to Medicaid when calculating Factor 2. A commenter stated that the writers of the Affordable Care Act could not have foreseen that such a drastic shift in insurance patterns would occur in a short amount of time, as a result of a pandemic.

Many commenters highlighted the proposed decrease of approximately $660 million in total uncompensated care payments in the FY 2022 proposed rule compared to estimated total uncompensated care payments for FY 2021, which, according to a commenter, conflicts with CMS' goal of advancing health equity and reducing healthcare disparities.

Commenters referred to the significant increase in unemployment due to the pandemic and stated that it seems counterintuitive that the percentage of uninsured decreased. Another commenter stated that the reduction in uncompensated care payments, in part because of a projected reduction in the number of uninsured individuals, is inconsistent with the increase in care that hospitals have provided to uninsured patients during the past year. Therefore, many commenters requested that for FY 2022 CMS maintain total uncompensated care payments at the current level for FY 2021, due to the pandemic. Some commenters recommended that CMS follow a similar path as in other IPPS policies proposed for FY 2022 and use FY 2019 data again in place of FY 2020 data when calculating the uninsured rates for Factor 2.

A commenter indicated that other government reports have contradicted many of the most important assumptions made concerning Factor 2. For example, the CBO issued a report on nationwide health insurance levels, which concluded that the Affordable Care Act had insured fewer individuals than previously estimated. Additionally, they noted that in the President's 2018

Economic Report, the Administration noted that not only was the overall coverage expansion less than initially expected, but it was also due more to Medicaid expansion than was initially projected.

A commenter also noted that in projecting coverage levels for FY 2022, the proposed rule assumed an under-reporting of Medicaid coverage "due to a perceived stigma associated with being enrolled in the Medicaid program or confusion about the source of their health insurance," yet there is nothing in the proposed rule to indicate that the agency has applied this same presumption of under reporting in calculating Factor 1, where increased Medicaid coverage would serve to increase expected DSH payments. The commenter concluded that it appears that the agency has applied internally inconsistent assumptions on Medicaid expansion between Factors 1 and 2 with no explanation.

Many commenters recommended using the latest available data when finalizing Factor 2. Commenters believed that using more timely and accurate data would reflect an increase in the uninsured population in FY 2021 and FY 2022. A commenter requested that CMS revisit its approach to calculating uncompensated care funding, as current data likely includes too much noise.

Response: We thank the commenters for their input and their recommendations regarding the estimate of Factor 2 included in the proposed rule. 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 for this final rule. 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 the rates of uninsurance for CY 2021 and CY 2022. We note that this approach takes into account relevant developments since publication of the proposed rule, including faster-than-anticipated employment growth, an improving economic outlook based on a consensus of the Blue Chip forecasters, and substantial recent and anticipated, temporary increases in Medicaid enrollment (associated in part with the

Maintenance of Effort requirement under the FFCRA for states to qualify to receive higher Medicaid payments during the PHE).

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 2022 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 better 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 also believe it is appropriate to update the NHEA-based projection of the FY 2022 rate of uninsurance that appeared in the proposed rule using recent unemployment data from BLS, and associated projections of that metric as published in the Blue Chip Economic Indicators report.

Many commenters requested that CMS consider the shifts from commercial insurance to Medicaid when calculating Factor 2. The projections utilized here capture shifts between insurance categories such as from commercial insurance to Medicaid and any resulting impact on the uninsured population. Regarding the comments recommending that we maintain total uncompensated care payments at the FY 2021 level, we note that section 1886(r)(2)(B)(ii) provides that Factor 2 should be determined by comparing the percent of individuals who are uninsured in 2013 with the number of individuals "who are uninsured in the most recent period for which data is available." Because data are available to permit OACT to estimate the rate of

uninsurance for CY 2021 and CY 2022, we believe using these data to estimate Factor 2 for FY 2022 is appropriate and consistent with the statute. In particular, maintaining total uncompensated care payments at the FY 2021 level would fail to reflect updated expectations regarding the level of uninsurance during FY 2022 associated with changing economic conditions, newly available data on Medicaid and Marketplace enrollment, the estimated impacts from the Families First Coronavirus Response Act (FFCRA), including the provision requiring a Medicaid Maintenance of Effort, the CARES Act, and the American Rescue Plan Act.

After consideration of the public comments we received, we are updating the calculation of Factor 2 for FY 2022 to incorporate more recent data, as we proposed. 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 2022 using a weighted average of OACT's updated projections for CY 2021 and CY 2022 is as follows:

- Percent of individuals without insurance for CY 2013: 14 percent.
- Percent of individuals without insurance for CY 2021: 9.8 percent.
- Percent of individuals without insurance for CY 2022: 9.5 percent.
- Percent of individuals without insurance for FY 2022 (0.25 times 0.098) + (0.75 times 0.095): 9.6 percent.

1- |((0.096-0.14)/0.14)| = 1-0.3143 = 0.6857 (68.57 percent). Therefore, the final Factor 2 for FY 2022 is 68.57 percent. The final FY 2022 uncompensated care amount is $ $10,488,564,546.74* 0.6857 = $ 7,192,008,709.70.

FY 2022 Final Rule Uncompensated Care Amount	$ 7,192,008,709.70

c. Calculation of Factor 3 for FY 2022

(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 for which section 1886(r) of the Act 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 would potentially provide 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 used alternative data on the utilization of insured low-income patients, as measured by patient days, which we believed 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 to use proxy data 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 and submitted on or after May 1, 2010, when the new Worksheet S-10 went into effect. However, 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 reported 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.

We also recognized commenters' concerns that, in continuing to use 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. In the FY 2018 IPPS/LTCH PPS final rule, we finalized a methodology under which we calculated Factor 3 for all eligible hospitals, with the exception of Puerto Rico hospitals and Indian Health Service (IHS) and Tribal hospitals, using Worksheet S-10 data from FY 2014 cost reports in conjunction with low-income insured days proxy data based on Medicaid days and SSI days. The time period for the Medicaid days data was FY 2012 and FY 2013 cost reports (82 FR 38208 through 38213).

As we stated in the FY 2019 IPPS/LTCH PPS final rule (83 FR 41414), with the additional steps we had taken to ensure the accuracy and consistency of the data reported on Worksheet S–10 since the publication of the FY 2018 IPPS/LTCH PPS final rule, we continued to believe that we could no longer conclude that alternative data to the Worksheet S–10 are currently available for FY 2014 that are a better proxy for the costs of subsection (d) hospitals for treating individuals who are uninsured. Similarly, the actions that we have taken to improve the accuracy and consistency of the Worksheet S–10 data, including the opportunity for hospitals to resubmit Worksheet S–10 data for FY 2015, led us to conclude that there were no alternative data to the Worksheet S–10 data currently available for FY 2015 that would be a better proxy for the costs of subsection (d) hospitals for treating uninsured individuals. Accordingly, in the FY 2019 IPPS/LTCH PPS final rule (83 FR 41428), we advanced the time period of the data used in the calculation of Factor 3 forward by 1 year and used Worksheet S-10 data from FY 2014 and FY 2015 cost reports in combination with the low income insured days proxy for FY 2013 to determine Factor 3 for FY 2019. We note that, as discussed in the FY 2020 IPPS/LTCH PPS final rule (84 FR 42366), the use of three years of data to determine Factor 3 for FY 2018

and FY 2019 had the effect of smoothing the transition from the use of low-income insured days to the use of Worksheet S–10 data.

As discussed in the FY 2019 IPPS/LTCH PPS final rule (83 FR 41424), we received overwhelming feedback from commenters emphasizing the importance of audits in ensuring the accuracy and consistency of data reported on the Worksheet S-10. 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.

In the FY 2020 IPPS/LTCH PPS final rule (84 FR 42368), we finalized our proposal to use a single year of Worksheet S–10 cost report data from FY 2015 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.

In the FY 2021 IPPS/LTCH PPS final rule (85 FR 58823 through 58825), we finalized our proposal to use the most recent available single year of audited Worksheet S-10 data to determine Factor 3 for FY 2021 and subsequent fiscal years. We explained our belief that 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. We noted that 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 also believed using a single year of audited cost report data is an appropriate methodology to determine Factor 3 for FY 2021 and subsequent years, except for IHS and Tribal hospitals and hospitals located in Puerto Rico. For IHS and Tribal hospitals and Puerto Rico hospitals, we finalized the use of a low-income insured days proxy to determine Factor 3 for FY 2021. We did not finalize a methodology to determine Factor 3 for IHS and Tribal hospitals and Puerto Rico hospitals for FY 2022 and subsequent years because we believed further consideration and review of these hospitals' Worksheet S–10 data was necessary (85 FR 58825).

In the FY 2021 IPPS/LTCH PPS final rule, we finalized the definition "uncompensated care" for FY 2021 and subsequent fiscal years, for purposes of determining uncompensated care costs and calculating Factor 3 (85 FR 58825 through 58828). We are continuing to use the definition that we had initially adopted in the FY 2018 IPPS/LTCH PPS final rule. Specifically, "uncompensated care" is 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 2021 IPPS/LTCH PPS rule (85 FR 58825 through 58828) for a discussion of additional topics related to the definition of uncompensated

care. We noted in the FY 2021 IPPS/LTCH PPS final rule 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. A PRA package with comment period appeared in the November 10, 2020 **Federal Register** (85 FR 71653). We thank stakeholders for their comments on the PRA package and we will respond to those comments in a separate **Federal Register** document.

(2) Background on the Methodology Used to Calculate Factor 3 for FY 2021 and Subsequent Fiscal Years

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 a subsection (d) 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 2021 IPPS/LTCH PPS final rule, we applied the following policies as part of the Factor 3 methodology: (1) the policy regarding newly merged hospitals that was initially adopted in the FY 2015 IPPS/LTCH PPS final rule; (2) the policies regarding annualization and long cost reports that were adopted in the FY 2018 and FY 2019 IPPS/LTCH PPS final rules, including a modified policy for the rare cases where a provider has no cost report for the fiscal year that is used in the Factor 3 methodology because the cost report for the previous fiscal year spans both years; (4) the modified new hospital policy that was finalized in the FY 2020 IPPS/LTCH PPS final rule; (5) the new merger policy adopted in the FY 2021 IPPS/LTCH PPS final rule that accounts for the merger effective date; and (6) 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 2021 IPPS/LTCH PPS final rule (85 FR 58829), we continued 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 past policy, interim uncompensated care payments for newly merged hospitals are based only on the data for the surviving hospital's CCN available the time of the development of the final rule. However, at cost report settlement, we will 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 will 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.

In FY 2021 IPPS/LTCH PPS final rule (85 FR 58829), we continued 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 adopted for FY 2021. In addition, we continued the policies that were finalized in the FY 2019 IPPS/LTCH PPS final rule (83 FR 41415) regarding the use of the longest cost report available within the Federal fiscal year. However, we adopted a modified 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 modified policy, we use the cost report that spans both fiscal years for purposes of calculating Factor 3 when data from the latter fiscal year are used in the Factor 3 methodology.

In the FY 2021 IPPS/LTCH PPS final rule (85 FR 58829 and 58830), we continued the 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 2021. Under the modified policy originally adopted for FY 2020, new hospitals that have a preliminary projection of being eligible for Medicare DSH based on their most recent available disproportionate patient percentages may receive interim empirically justified DSH payments. However, because these hospitals did not have a FY 2017 cost report to use in the Factor 3 calculation and the projection of eligibility for DSH payments was 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 2021 cost report. If the hospital is ultimately determined to be eligible for Medicare DSH payments for FY 2021, 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 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.

In the FY 2021 IPPS/LTCH PPS final rule, we finalized a new merger policy that accounts for the merger effective date (85 FR 58828 through 58829). 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 finalized a policy of not annualizing the acquired hospital's data. Under this policy, we 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. To do this, we calculate a multiplier to be applied to the acquired hospital's UCC. This multiplier represents the portion of the UCC data from the acquired hospital that should be incorporated with the surviving hospital's data to determine UCC for purposes of determining Factor 3 for the surviving hospital. This multiplier is obtained by calculating the number of days between the start of the applicable cost reporting period for the surviving hospital and the merger effective date, and then dividing this result by the total number of days in the reporting period of the acquired hospital. Applying this multiplier to the acquired hospital's unannualized UCC data will determine the final portion of the acquired hospital's UCC that should be added to that of the surviving hospital for purposes of determining Factor 3 for the merged hospital.

In the FY 2021 IPPS/LTCH PPS final rule (85 FR 58831 and 58832), we continued to apply a CCR trim methodology similar to the CCR trim methodology policy that has been used for purposes of determining uncompensated care payments since FY 2018. This CCR trim methodology is 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. We refer readers to the discussion in the FY 2021

IPPS/LTCH PPS final rule (85 FR 58831) for a detailed description of the steps used to determine the applicable CCR.

In addition, we continued the UCC data trim methodology for rare situations where a hospital has potentially aberrant data that are unrelated to its CCR (85 FR 58832). However, because we had audited the FY 2017 Worksheet S–10 data for a number of hospitals, we explained that we no longer believe it is necessary to apply the trim methodology for hospitals whose cost report has been audited. Accordingly, for FY 2021 we finalized a policy under which we exclude hospitals that were part of the audits from the trim methodology for potentially aberrant UCC. In the FY 2021 IPPS/LTCH PPS final rule (85 FR 58831), we also modified the potentially aberrant UCC trim methodology when it is applied to all-inclusive rate providers (AIRPs). Under this modified trim methodology, 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 will recalculate the AIRP's UCC using the CCR reported on Worksheet S–10, line 1 of the hospital's most recent available prior year cost report that does not result in UCC of over 50 percent of total operating costs.

In the FY 2021 IPPS/LTCH PPS final rule (85 FR 58824 and 58825), 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 for IHS and Tribal hospitals and subsection (d) Puerto Rico hospitals that have a FY 2013 cost report. 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).

We refer readers to the FY 2021 IPPS/LTCH PPS final rule (85 FR 58817) for a discussion of the approach that we continued in FY 2021 to determine Factor 3 for new Puerto Rico hospitals. 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 discussed previously. Specifically, the numerator of the Factor 3 calculation will be the uncompensated care costs reported on Worksheet S–10 of the hospital's cost report for the applicable fiscal year and the denominator is the same denominator that is determined prospectively for purposes of determining Factor 3 for all DSH-eligible hospitals.

Therefore, for FY 2021, we finalized the following methodology to compute Factor 3 for each hospital:

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.

Step 4: Calculating Factor 3 for IHS 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 a 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 2018 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 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 stated that the methodology adopted in the FY 2021 IPPS/LTCH PPS final rule for purposes of determining Factor 3 for FY 2021 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. However, we did not finalize a methodology to determine Factor 3 for FY 2022 and subsequent years for IHS and Tribal hospitals and Puerto Rico hospitals that have a FY 2013 cost report because we believed further consideration and review of these hospitals' Worksheet S–10 data is necessary.

We amended the regulations at § 412.106(g)(1)(iii)(C) by adding a new paragraph (7) to reflect the methodology for computing Factor 3 for FY 2021. We also added a new paragraph (8) to reflect the policy adopted for all subsequent fiscal years of using 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 and Puerto Rico Hospitals.

(3) Methodology for Calculating Factor 3 for FY 2022

(a) Use of Audited FY 2018 Data to Calculate Factor 3 for FY 2022

Audits of FY 2018 cost reports began in 2020 and those audited reports were available, in time for the development of the proposed rule. Feedback from the audits of the FY 2015 and FY 2017 reports and lessons learned were incorporated into the audit process for the FY 2018 reports. We again chose to audit 1 year of data (that is, FY 2018) 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 2018 Worksheet S-10 data are the most recent available audited data, in the FY 2022 IPPS/LTCH PPS proposed rule, we stated that we believe, on balance, that the FY 2018 Worksheet S-10 data are the best available data to use for calculating Factor 3 for FY 2022. As 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 2018 data for a hospital may be relatively different from its FY 2017 data (whether audited or unaudited), 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 2022. In the FY 2022 IPPS/LTCH proposed rule, we recognized that the FY 2017 reports also include audited data for some hospitals. However, the FY 2018 cost reports are the most recent year of audited data and, and reflect the revisions to the Worksheet S-10 cost report instructions that were effective on October 1, 2017.

Accordingly, consistent with the policy adopted in the FY 2021 IPPS/LTCH PPS final rule and codified in the regulations at § 412.106(g)(8), in the FY 2022 IPPS/LTCH PPS proposed rule we used a single year of Worksheet S–10 data from FY 2018 cost reports to calculate Factor 3 for FY 2022 for all eligible hospitals with the exception of IHS and Tribal hospitals and Puerto Rico hospitals that have a cost report for 2013. 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. In the proposed rule, we noted that the proposed uncompensated care payments to hospitals whose FY 2018 Worksheet S–10 data have been audited represent approximately 99.6 percent of the proposed total uncompensated care payments for FY 2022. For purposes of the FY 2022 IPPS/LTCH PPS proposed rule, we used a

HCRIS extract updated through February 19, 2021. We also noted that we intended to use the March 2021 update of HCRIS for the FY 2022 final rule and the respective March updates for all future final rules. However, we also indicated that we might consider the use of more recent data that may become available after March 2021, but prior to the development of the final rule, if appropriate, for purposes of calculating the final Factor 3 for the FY 2022 IPPS/LTCH PPS final rule. We invited public comments on our proposed methodology for calculating Factor 3 for FY 2022, including, but not limited to, our proposed use of FY 2018 Worksheet S-10 data (86 FR 25457).

Comment: Several commenters expressed general support for the use of audited Worksheet S–10 data to estimate each hospital's share of uncompensated care costs in FY 2022 and/or in future years. Commenters commended CMS for its efforts to ensure the accuracy and consistency of the data reported through revised instructions and ongoing refinements to the audit process.

A commenter expressed concerns about the validity and comparability of Worksheet S–10 data, especially in the absence of auditing all DSH-eligible 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." A commenter recommended that CMS eliminate the reliance on Worksheet S-10 data as a measure of uncompensated care because Worksheet S-10 methodology does not account for hospitals with high levels of uncompensated care from patients on public insurance. The commenter noted that these hospitals with high uncompensated care are unable to offset their charity care and bad debt losses with additional sources such as direct taxes or state and local appropriations. They recommended that CMS develop a measure that acknowledges those inherent problems or make exceptions and provide specific protections for hospitals that serve very low-income and medically complex populations. Another

commenter requested that CMS ensure its methodology for determining UC payments accurately captures the full range of UC costs that hospitals incur when treating low-income and uninsured individuals to ensure safety net hospitals receive adequate support.

Response: We appreciate the support for our policy of using the most recent year of audited 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 that expressed concerns that Worksheet S–10 data lack validity and are not comparable across hospitals, we note that consistent with the policy adopted in the FY 2021 IPPS/LTCH PPS final rule, we are continuing to use audited Worksheet S–10 cost report data to determine Factor 3 for FY 2022. Our decision to adopt a policy of using audited Worksheet S-10 data to determine Factor 3 was 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). Additionally, we have conducted audits of the FY 2018 Worksheet S–10 data for an expanded number of hospitals, and we have begun auditing the FY 2019 Worksheet S–10 data 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 continue to believe 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 2018 Worksheet S–10 data for the calculation of Factor 3 for FY 2022. Commenters noted that the FY 2018 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. Commenters supporting the continued use of Worksheet S-10 data also indicated that the FY

2018 cost reports are the most extensive as significantly more hospitals underwent Worksheet S-10 audits. In addition, some commenters indicated that the FY 2018 cost reports reflect the improvements called for under the most recent revised Worksheet S–10 instructions.

However, many other commenters expressed opposition to using a single year of Worksheet S–10 data in the calculation of uncompensated care payments for FY 2022 and future years. The primary concern expressed by these commenters was the possibility that such an approach would lead to significant variation in year-to-year uncompensated care payments, especially in light of external factors that may affect a hospital's finances on a one-time basis. These commenters pointed to CMS' 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, while also ensuring accuracy, stability, and predictability for providers. Some stakeholders indicated that CMS will no longer have to be concerned about mixing audited and unaudited data from multiple years as the agency continues to audit Worksheet S-10 data each year.

The most common alternative recommended by commenters who opposed the use of a single year of FY 2018 data for the calculation of Factor 3 in FY 2022 was the use of two years of historical Worksheet S–10 data. Several commenters recommended a transitional period where FY 2017 and FY 2018 Worksheet S-10 data would be used to determine Factor 3 for FY 2022, because both years have been subject to audits. These commenters also suggested the use of FY 2017, FY 2018, and FY 2019 data to determine FY 2023 uncompensated care payments, followed by the continued use of three years of audited Worksheet S-10 data thereafter. As an alternative, a commenter suggested the use of audited FY 2018 and FY 2019 data to determine Factor 3 for FY 2023, and a subsequent transition to using three years of audited data for the FY 2024 uncompensated care payments, if using data from more than one year's cost report for FY 2022 was not feasible.

Some commenters acknowledged the efforts CMS has taken to improve the accuracy of Worksheet S-10 data through the audit process. Yet, several commenters expressed concerns about the accuracy and reliability of using a single year of Worksheet S-10 audited data. Some commenters requested that CMS further monitor uncompensated care payments over time for potential anomalies and fluctuations. Other commenters recommended CMS consider omitting or making appropriate adjustments to cost report data due to the effects of the COVID-19 public health emergency (PHE) when calculating Factor 3 and determining the distribution of uncompensated care payments in future years. In addition, a commenter suggested that CMS regularly assess the cost report data for irregular trends and their potential impact on the allocation of uncompensated care payments.

Response: We are grateful to those commenters who expressed their support for using the FY 2018 Worksheet S–10 data to determine each hospital's share of uncompensated care costs in FY 2022. As noted in the FY 2022 IPPS/LTCH PPS proposed rule, we believe, that, on balance, the FY 2018 Worksheet S-10 data are the best available data to use for calculating Factor 3 for FY 2022.

Regarding the commenters' suggestion of using multiple years of audited Worksheet S-10 data, we will consider using multiple years of data when the vast majority of providers have been audited for more than one fiscal year under the revised reporting instructions. We expect that the number of audits will continue to increase from previous years. Further, 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 2018 Worksheet S-10 data for a hospital are relatively different from its audited or unaudited FY 2017 Worksheet S-10 data (for example, as a general statement, audits can materially impact a hospital's 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 2022. For

example, there are some unaudited FY 2017 reports that have a larger than $5 million absolute difference in uncompensated care costs between a hospital's unaudited FY 2017 report and a hospital's audited FY 2018 report. We believe using the most recent year of audited data is an appropriate methodology for DSH uncompensated care payments.

As explained in the FY 2021 IPPS/LTCH PPS final rule (85 FR 58820), we also note that if a blend of multiple years of cost report data (for example, FY 2017, FY 2018, and/or FY 2019) 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 of 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 2018 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 2018 cost reports reflect the first year of data reported under the revised to Worksheet S–10 instructions that were effective on October 1, 2017, and have further improved the data quality. Accordingly, consistent with the regulation at § 412.106(g)(1)(iii)(C)(8), we will calculate Factor 3 for FY 2022 using FY 2018 Worksheet S-10 data, which is the most recent cost reporting year for which audits have been conducted and which we continue to believe is the best available data for purposes of calculating Factor 3 for FY 2022.

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 under the revised reporting instructions. Regarding the commenters' suggestions for FY 2023 and FY 2024, we are not making any modifications to our existing policy on calculating Factor 3 for future fiscal years at this time. We will continue to monitor

uncompensated care payments for fluctuations and evaluate any anomalies as we move forward with using only one year of audited Worksheet S-10 data for Factor 3 calculations.

Regarding commenters' concerns about and suggestions for addressing the impact of the COVID-19 PHE in future years, we believe it would be premature to attempt in this rulemaking to modify the methodology for calculating Factor 3 or determining uncompensated care payments for a future fiscal year. We will consider this issue further in future rulemaking when the FY 2020 and FY 2021 cost reporting data are more fully available to be analyzed.

The following comments relate to the definition of uncompensated care costs:

Comment: With regard to the definition of uncompensated care, several commenters urged CMS to include unreimbursed costs (shortfalls) from Medicaid, CHIP, and State and local indigent care programs. According to commenters, these shortfalls represent substantial losses as those programs often do not fully cover the cost of providing care. Several commenters also argued that including Medicaid shortfalls as uncompensated care in Worksheet S–10 is especially important for hospitals in states that have expanded Medicaid. According to the commenters, these hospitals tend to be worse off under the current definition of uncompensated care, as compared to hospitals in states that did not expand. Some commenters provided CMS with methodologies for how to account for Medicaid shortfalls, including a recommendation that CMS develop a measure similar in nature to the Medicaid low-income utilization rate (LIUR) formula that includes Medicaid shortfalls and uninsured care rates to calculate uncompensated care costs for purposes of Factor 3. Another commenter suggested specific revisions to Worksheet S–10 to better reflect the actual Medicaid shortfalls incurred by hospitals. These revisions included allowing hospitals to include all GME-related costs and to reduce their Medicaid revenue by the amount of any contributions to funding the nonfederal share of the Medicaid program, whether through provider taxes, intergovernmental transfers (IGTs), or certified public expenditures (CPEs).

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 continue to believe there are compelling arguments for excluding such shortfalls from the definition of uncompensated care. First, we note that we did not propose any changes to the definition of uncompensated care costs, which was finalized in the FY 2021 IPPS/ LTCH PPS final rule 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). Additionally, 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. 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.

Comment: Commenters also suggested that CMS include all patient care costs when calculating the cost to charge ratio (CCR) used in Worksheet S–10, including costs associated with training medical residents, supporting physician and professional services, and paying provider taxes, so as to determine uncompensated care costs more accurately for purposes of the Worksheet S–10. A commenter also suggested that CMS incorporate the costs of organ transplant programs into the CCR calculation as hospitals incur significant costs related to uninsured and underinsured populations that are not addressed through payments for organ acquisition costs.

Response: As we have consistently stated in past final rules (84 FR 42378 and 85 FR 58826) 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.

Additionally, 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 organ transplant programs, supporting physician and professional services and GME, we remain hesitant to adjust CCRs in the narrower context of calculating uncompensated care costs. Therefore, as stated in past final rules, we continue to believe that it is not appropriate, at this time, 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.

For issues related to the cost report instruction, which are beyond the scope of this rulemaking, we refer commenters to the forthcoming Paper Reduction Act (PRA) package comment period for Form 2552-10 (OMB Control Number 0938–0050), which will be the appropriate forum for recommending modifications to Worksheet S–10.

Comment: Some stakeholders offered suggestions regarding the uncompensated care payment calculation that appear to be outside the scope of the policies discussed in the proposed rule. One such comment included a recommendation that CMS change the distribution of uncompensated care payments and set a cap on uncompensated care payments, for instance, by implementing a statistical trim threshold on uncompensated care costs reported on the Worksheet S-10 costs that are greater than 40% of Worksheet A expenses. These commenters also suggested that uncompensated care payments in excess of the cap could be redistributed to all other eligible hospitals. Another commenter suggested that hospitals that report aberrant uncompensated care costs on their Worksheet S-10 be penalized by receiving a Factor 3 of 0, rather than a Factor 3 determined using our trim methodology.

In addition, some commenters requested that CMS consider policies to mitigate the effect of the COVID–19 PHE on FY 2020 and FY 2021 cost reports, which will impact future uncompensated care distributions for FY 2024 and FY 2025. In relation to this recommendation, several commenters suggested that CMS consider and/or finalize a policy that would preclude using FY 2020 and FY 2021 Worksheet S-10 data to calculate Factor 3, as these data will likely be affected by COVID-19 PHE and are likely to be unrepresentative of other years, given the unique pressures that hospitals faced during that time.

Response: We thank commenters for their continued concern regarding the distribution of uncompensated care payments and the impact of the COVID-19 PHE on future uncompensated care payments distributions. Regarding commenters' recommendation that we implement a cap on uncompensated care payments, we believe that our policy for trimming uncompensated care costs that are an extremely high ratio, greater than 50 percent, of a hospital's total operating costs for the same year as described the FY 2021 final rule (85 FR 58832), balances our desire to exclude potentially aberrant data with our concern regarding inappropriately reducing uncompensated care payments to a hospital that may have a legitimately high ratio as determined

through an audit of their Worksheet S–10 data. Additionally, we note that the statutory language governing Factor 3 does not specify any upper limit to a hospital's uncompensated care payment.

Regarding the commenter's suggestion that hospitals with aberrant cost report data get penalized with a Factor 3 of 0, we note that consistent with the policies adopted in the FY 2021 IPPS/LTCH final rule we intend to continue our policy of trimming potentially aberrant CCRs by applying the state-wide average CCR for providers with a CCR above the proposed ceiling. As discussed previously, we will also continue to implement the trim methodology for potentially aberrant UCC for purposes of determining Factor 3. In addition, for FY 2022, we proposed to trim potentially aberrant charity care cost data for hospitals that are currently not projected to be DSH eligible and do not have audited FY 2018 Worksheet S-10 data by excluding the hospital from the prospective Factor 3 calculation if that hospital's insured patient's charity care costs exceed a threshold of 60 percent of total uncompensated care costs and a dollar threshold of $7 million. We believe these policies appropriately address potentially aberrant data in UCC distribution for the purposes of calculating Factor 3.

The commenters' suggestion that we adjust the methodology for determining uncompensated care costs in this rulemaking to reflect the impact of the COVID–19 PHE is premature. Moreover, it is not clear at this time what methodology would be used to determine any such an adjustment and what data source could be used. Because cost reporting data for the period covered by the COVID–19 PHE 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 intend to consider the potential impact of the COVID-19 PHE on the determination of uncompensated care costs in future rulemaking, as appropriate.

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

Comment: As in previous years, the auditing process for the FY 2018 Worksheet S–10 was a common topic among many commenters. Several commenters agreed that the data from

audited FY 2018 Worksheet S–10s have improved in accuracy when compared to previous years of data and cover a larger share of DSH-eligible hospitals. Other commenters also commended CMS' efforts to improve the Worksheet S–10 data through the audit process and revised instructions. Some commenters agreed that the use of audited Worksheet S-10 data is the most appropriate for calculating Factor 3 and determining DSH payments. A commenter supported CMS' approach of focusing its limited audit resources on the hospitals receiving the highest amounts of uncompensated care payments.

Still, many commenters expressed concerns with the Worksheet S–10 audits. Several commenters recommended that CMS implement a comprehensive audit process and expand the Worksheet S-10 audits to include all DSH-eligible hospitals receiving uncompensated care payments. In contrast, a commenter recommended that CMS audit a reasonable fraction of providers each year, such as one-third of DSH hospitals, and implement a three year rotation to audit all DSH hospitals over the course of three rulemaking cycles.

Some commenters requested that CMS decrease the provider burden associated with Worksheet S-10 audits, such as by minimizing the significant investment of time and resources required to prepare the necessary audit documentation for auditors. Stakeholders also urged CMS to conduct consistent and equitable audits across providers. Others suggested that CMS revisit the scope of the audits to target specific data elements, which would decrease provider burden.

Additionally, a few commenters suggested that CMS ensure transparency and consistency in the audit process by making the audit materials and protocols publicly available. A commenter also requested that CMS promulgate the audit policy and protocols through notice and comment rulemaking. Some commenters suggested that the Medicare Wage Index audit process could be a model for Worksheet S-10 audits. A commenter referred to the IRS Form 990 audits as separate example. This commenter asserted that the IRS Form 990 audits have been completely different from the Worksheet S-10 audits of uncompensated costs, and stated that the hospitals' IRS audits have not resulted in disallowance.

Other commenters urged CMS to develop a transparent timeframe for the audit process, with communication to providers about expectations and adequate lead time to avoid short response times. A commenter urged CMS to complete audits well in advance of future rulemaking to ensure that cost report data are accurate and available to be used in determining Factor 3. They also requested that CMS establish a standardized and streamlined process across auditors, which would include clear timelines for information submission and guidance on acceptable documentation to meet audit requirements. A commenter also requested that CMS select hospitals for audits in an equitable way and disclose the criteria used to identify hospitals subject to audits.

Commenters noted the need for a timely review and appeals process for any adverse findings or inconsistent audit disallowances. Additionally, commenters urged CMS to consider seeking input from hospitals and working with MACs in developing the Worksheet S–10 audit process to further promote clarity and consistency. To this end, a commenter requested that CMS review audit findings to ensure MACs and their subcontractors are applying audit protocols consistently across hospitals nationwide. A commenter urged CMS to implement fatal edits to ensure that the Worksheet S-10 is submitted completely and is internally consistent, and to instruct MACs to audit negative, missing, or suspicious information.

As part of requesting stability in the Worksheet S-10 audit process, a commenter expressed their concerns with the inconsistent and different sampling and extrapolation techniques employed by MACs during Worksheet S-10 audits. They highlighted the different sampling methods and error rate thresholds used to justify extrapolation, which the commenter believes have produced varied outcomes for hospitals and could impact uncompensated care payments. In addition, this commenter requested that CMS apply the same audit criteria that are used for retrospective audits of empirically justified DSH payments, which are determined using SSI/ Medicare and Medicaid eligible days. The commenter also stated that hospitals should have

the same protections afforded by the appeal rights available for empirically justified DSH payments.

Response: We thank commenters for their feedback on the audits of the FY 2018 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, in order to assure consistency during the audit process. We began auditing the FY 2018 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 2022 IPPS/LTCH PPS proposed rule. We chose to focus the audit on the FY 2018 cost reports in order to maximize the available audit resources. We also note that FY 2018 data are the most recent year of audited data reported under the revised cost report instructions that were effective on October 1, 2017.

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 2019 Worksheet S–10 data. We recognize that a number of commenters have suggested we audit all hospitals. However, as discussed in the FY 2022 IPPS/LTCH PPS proposed rule (86 FR 25453), we note that the proposed uncompensated care payments to hospitals whose FY 2018 Worksheet S–10 data have been audited represent approximately 99.6 percent of the proposed total uncompensated care payments for FY 2022, which is an increase from the 65 percent captured in the FY 2017 audits. While our limited audit resources mean that it is not feasible to commit to auditing all hospitals every year, we will continue to expand the number of audited providers captured in the FY 2019 audits, as was done in the FY 2018 audits. We expect the number of audits will continue to increase over time, resulting in improved Worksheet S-10 data over the years.

We appreciate all commenters' input and recommendations on how to improve our audit process and reiterate our commitment to continue working with the MACs and providers on audit improvements, including changes to increase the efficiency of the audit process and build

on the lessons learned in previous audit years. Regarding commenters' requests for a standard audit timeline, we do not intend to establish a fixed timeline for audits across MACs at this time 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 that we make public the audit instructions and criteria, as we previously stated in the FY 2021 IPPS/LTCH final rule (85 FR 58822) 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. Concerning the request that we promulgate the Worksheet S-10 audit policy and protocols through notice and comment rulemaking, we do not believe it would be appropriate to seek comment on audit protocols that are confidential. Rather, it is sufficient that we provide stakeholders with notice of our proposed methodology for determining uncompensated care payments and the data sources that will be used, so that they may have a meaningful opportunity to submit their views on the proposed methodology and the adequacy of the data for the intended purpose.

Regarding commenters' recommendations that we establish a timely review and appeals process for the Worksheet S–10 audits, we do not intend on introducing such a process at this time in order to maximize limited audit resources. However, we will continue to work with stakeholders to address their concerns regarding the accuracy and consistency of data reported on Worksheet S-10. We will also continue to work with the MACs each year to further improve the consistency of the audit process across providers and MACs.

Concerning the suggestion to implement a fatal edit on Worksheet S– 10, we note that we did not propose any additional edits to Worksheet S-10 data in the FY 2022 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 "fatal" edits to the Worksheet S–10 data.

Concerning the commenter's request that we 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. As explained previously, we continue to believe that audit protocols (for example, criteria) should be confidential, so we disagree with the commenter about making 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.

The following comments relate to the Worksheet S–10 cost report instructions:

Comment: With regard to Worksheet S-10 instructions, a commenter appreciated the effort CMS has undertaken to improve the clarity of the Worksheet S-10 instructions. Some commenters also offered suggestions for CMS' calculation of uncompensated care costs, including possible changes to Worksheet S-10. Specifically, a commenter mentioned that multiplying the CCR by copayment amounts written off as charity care significantly understates the cost of charity care as these amounts have already been reduced through rate negotiation with the payor. Accordingly, the commenter requested that CMS instruct hospitals to report copayments for insured patients that are to be written off as charity care in Column 2, line 20, thereby excluding them from costs reduced by the CCR. Another commenter requested that CMS clarify the instructions for line 29 of the Worksheet S-10 regarding non-Medicare bad debt for insured patients and urged the agency not to apply the CCR to these amounts, adding that making this change would be consistent with the way CMS treats non-reimbursed Medicare bad debt.

Another commenter observed that Worksheet S-10 fails to account for all patient care costs when determining uncompensated care costs by ignoring the costs hospitals incur in

training residents, supporting physicians and professional services, and provider taxes related to Medicaid revenue. The commenter requested that the agency refine Worksheet S-10 to include these costs. In particular, the commenter suggested that in calculating the CCR, the agency "use total of Worksheet A, column 3 lines 1 through 17, reduced by the amount of worksheet A-9, line 10, as the cost component; and use worksheet C, column 8, line 200, as the charge component." According to the commenter, implementing this change would incorporate additional patient care costs incurred by hospitals, such as Graduate Medical Education (GME). Similarly, another commenter requested that CMS include teaching costs in determining uncompensated care costs on line 30 of Worksheet S-10 because excluding these costs disproportionately affects teaching hospitals and academic medical centers.

In addition, a commenter suggested that just as unreimbursed costs for charity care patients are recognized as uncompensated care costs, so should the shortfall of state or local indigent care programs, adding that CMS should also refine Worksheet S-10 data on Medicaid shortfalls to better resemble actual shortfalls incurred by hospitals. To this end, the commenter recommended that a more accurate measure of Medicaid shortfalls could include the incorporation of GME costs in the CCR. Another recommendation was that CMS allow hospitals to reduce Medicaid revenues by intergovernmental transfers (IGTs), provider reimbursement taxes, or certified public expenditures (CPEs). While the commenter agreed that Medicaid shortfalls, as currently reported on Worksheet S-10, should not be included in the uncompensated care cost estimation, they added that these data will be increasingly useful for informational purposes as more individuals gain access to Medicaid coverage. Similarly, a couple of other commenters requested that CMS undertake additional efforts to include a hospital's Medicaid shortfalls by incorporating line 31 of Worksheet S-10 into the calculation of a hospital's uncompensated care costs in Factor 3.

A commenter stated that CMS should afford providers with ample opportunities to provide feedback and receive education on Worksheet S-10 instructions and requested that CMS

clearly communicate regarding revisions to cost report instructions and cost report submission deadlines. The commenter further recommended that CMS provide additional outreach and educational materials to hospitals about Worksheet S-10. Another commenter encouraged CMS to postpone the implementation of revisions to form CMS-2552-10, Hospital and Health Care Complex Cost Report, to allow providers more time to implement the required operational changes that the revisions would entail.

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 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. We also encourage providers to discuss with their respective MACs any questions regarding clarifications of instructions and/or reporting.

We continue to believe that our efforts to refine the instructions have improved provider understanding of the Worksheet S–10 and added clarity to the instructions, as noted by a commenter. 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 provider outreach. However, as stated in previous rules, we continue to believe that the Worksheet S–10 instructions are sufficiently clear and 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, as well as the recommendation that we postpone the implementation of revisions to Form CMS–2552–10 (OMB Control Number 0938–0050, expiration date March 31, 2022) , 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 comment period for the Worksheet S–10, which will be the appropriate forum to raise

specific questions about or suggestions for modifications and clarifications to Worksheet S–10, including the reporting instructions.

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.

● *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 may jeopardize these hospitals' payments due to their unique funding structure. Prior to the proposed rulemaking for FY 2022, CMS consulted with IHS and Tribal hospitals regarding uncompensated care reporting. We are considering the input received through this consultation with IHS and Tribal hospitals for future rulemaking.

Therefore, for IHS and Tribal hospitals, we proposed to continue the policy first adopted in the FY 2018 rulemaking regarding the low-income patient proxy. Specifically, for FY 2022 we proposed to determine Factor 3 for these hospitals based on Medicaid days for FY 2013 and the most recent available year of data on 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. As we explained in the FY 2022 IPPS/LTCH PPS proposed rule (86 FR 24543), 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. We also note that all IHS and Tribal hospitals have a FY 2013 cost report that can be used for purposes of determining Factor 3. 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, 2021, and the FY 2018 SSI days.

Comment: Commenters expressed support for CMS' proposal to continue using low-income patient days as a proxy to calculate Factor 3 IHS and Tribal hospitals for FY 2022, with a commenter suggesting the use of the proxy in future years as well. Another commenter recommended that in subsequent years CMS allow Indian Health Care Provider (IHCP) hospitals the option of continuing to use the low-income days proxy measure or data from Worksheet S-10 to calculate uncompensated care amounts for the purposes of determining uncompensated care payments. Several commenters reiterated their support for a modified policy of paying Tribal and IHS hospitals 100% of Medicare DSH and requested that CMS explain why they did not propose this policy again.

A commenter also expressed dismay that CMS has yet to address the concerns previously mentioned with regard to the application of the uncompensated care cost policy to IHS and Tribal hospitals. The commenter requested that at a minimum, CMS give stakeholders one year to provide comments on a proposed policy and allow an additional three years as an implementation phase for the newly developed methodology.

The commenter indicated that, in the event uncompensated care payments for IHS and Tribal hospitals were to be determined using Worksheet S–10 data, 26 facilities with less than 100 beds would stand to collectively lose $7.5 million in DSH payments, while the two largest facilities would stand to gain $6.9 million. The commenter 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. They recommended that CMS remove the 12 percent cap as this "would advance the intent of the Congress to maximize Federal resources for the Indian health system."

The commenter added that if the 12 percent cap cannot be addressed via a statutory fix, CMS should work with hospitals to adopt changes to the methodology for calculating uncompensated care and charity care that address the unique circumstances of the Indian health system so that the disproportionate impact of the cap is offset. Further, while the commenter recognized that the cap "is statutorily imposed by the MMA [Medicare Modernization Act] and that CMS cannot act unilaterally to change it," they proposed that the agency work with Congress to remove the cap from all IHS and Tribal hospitals.

The commenter also 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 added that the inability to charge any Indian for services, including copays, and the provisions contained within treaties with the Federal Government and judicial rulings, mean that these hospitals are subject to a very unique method of calculating uncompensated care costs. The commenter maintained that the calculation of uncompensated care payments should be done in such a way as to maximize these hospitals' access to Federal resources. The commenter suggested that CMS work with IHS and Tribal facilities as well as the consortium to provide guidance on how these facilities should report uncompensated care on Worksheet S-10. In this regard, another commenter expressed that a significant challenge for IHS and Tribal hospitals is that CMS may be interpreting that "IHCPs do not have uncompensated care costs under Worksheet S–10, because base funding for the costs of patient care is provided through Congressional appropriations and might construe this as all care being considered compensated." However, commenters state that IHS appropriations do not fully fund the costs of care and that many tribal health programs invest non-Federal resources "to furnish care that could easily be classified as uncompensated care since IHCPs may not charge beneficiaries to receive care and, thus, may not have the accounting methods to track these costs." In summary, the commenter stated that IHCP hospitals are currently unable to report

charity care and non-Medicare bad debt in a way that is consistent with the definition of uncompensated care in the regulation.

Additionally, a commenter stated that the information technology systems used by IHS and Tribal hospitals are not equipped to collect the necessary data for the Worksheet S–10, noting that while IHS recently received funding to upgrade its information technology system, it will take some time, potentially years, before it is fully functional. The commenter urged CMS to work and consult with IHS to develop any new proposed methodology for calculating uncompensated and charity care for IHS and Tribal hospitals that would be used as an alternative to Worksheet S-10 to ensure that it accurately captures uncompensated and charity care provided by these facilities. Another commenter requested that CMS take additional time to work with the Tribal Technical Advisory Group and IHS and Tribal hospitals in the event it transitions these facilities to a new payment methodology for the calculation of Medicare DSH payments.

Response: We also appreciate the concerns raised and the input offered by commenters regarding the methodology for calculating uncompensated care payments for IHS and Tribal hospitals. We continue to recognize the unique nature of these hospitals and the special circumstances IHS and Tribal hospitals 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 for the FY 2023 rulemaking. 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 our proposal to use the low-income insured days proxy to determine Factor 3 for IHS and Tribal hospitals for FY 2022.

● *Puerto Rico Hospitals*

In the FY 2021 IPPS/LTCH PPS proposed rule, we proposed to determine Factor 3 for Puerto Rico hospitals using Worksheet S-10 data starting in FY 2022. We did not finalize this

proposal in the FY 2021 IPPS/LTCH PPS final rule (85 FR 58825) because we believed further consideration was necessary. However, we noted that we continued to believe Worksheet S-10 data is the appropriate long-term source for information on uncompensated care for hospitals located in Puerto Rico.

As explained in the FY 2022 IPPS/LTCH PPS proposed rule (86 FR 25453), we are continuing to consider the reporting challenges in Puerto Rico that may negatively impact the ability of Puerto Rico hospitals to report uncompensated care. Accordingly, for FY 2022 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 available year of data on 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. 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 data on SSI days, which was the 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).

Comment: Several commenters supported CMS' proposal to continue the use of low-income days as a proxy for hospitals located in Puerto Rico for FY 2022. Commenters also supported the use of 14 percent of a hospital's Medicaid days to determine SSI days for hospitals in Puerto Rico, as finalized in the 2017 Inpatient IPPS/LTCH PPS final rule. A commenter noted that using the Worksheet S-10 to calculate uncompensated care costs for hospitals located in

Puerto Rico would have a severe, unfavorable economic effect, which would exacerbate the already precarious financial conditions these hospitals face. This commenter suggested that CMS consider allowing a period of at least four to five years under the low-income days proxy to evaluate the "advancement done in the accounting methodology and reimbursement factor for PR [Puerto Rico]."

According to the commenter, a transition to the Worksheet S-10 would risk the financial stability of 40 percent of hospitals in Puerto Rico, which have already incurred significant losses as a result of the COVID-19 pandemic. The commenter expressed concern that the Worksheet S-10 has an "implied penalty" for Puerto Rico hospitals due to their low-cost structure as compared to higher cost hospitals located in the mainland US., adding that using Worksheet S-10 to calculate Factor 3 would not account for the deficiency in Medicaid reimbursement for Puerto Rico Hospitals. The commenter also stated that Puerto Rico's government health program, known as VITAL, covers approximately 1.2 million inhabitants of the total 3 million population of Puerto Rico. The commenter stated that "several services not paid by the insurance companies contracted by the Puerto Rico Government to provide services to VITAL's beneficiaries are absorbed by the hospital because the coverage provided by VITAL does not allow the hospital to collect such unpaid services from the patient." Additionally, the commenter stated that currently some hospitals in Puerto Rico do not have a charity care policy, even though they provide charity care services. Instead, these services are often inappropriately accounted for as a "contractual adjustment." The commenter further explained that those hospitals in Puerto Rico with a charity care policy in place do not know how to optimize their accounting systems to accommodate such policies, adding that hospitals may also be inappropriately accounting for bad debts. The commenter concluded that all of these factors understate the components of uncompensated care

costs, and that technical education is needed to address the challenges Puerto Rico hospitals have regarding charity care and bad debt reporting, which would take years to address.

Response: We appreciate the concerns raised by commenters regarding the calculation of Factor 3 for hospitals in Puerto Rico. Regarding the recommendation that we provide Puerto Rico hospitals a 4- to 5-year continuation of the current policy before the transition to the use of Worksheet S-10, we continue to invite commenters to provide further input as we revisit the use of Worksheet S-10 data from Puerto Rico hospitals in the Factor 3 methodology in future rulemaking and assess the results of FY 2019 audits for these hospitals. We will consider the commenters' concerns regarding the unique financial circumstances and challenges faced by Puerto Rico hospitals related to uncompensated care cost reporting on Worksheet S-10 in future rulemaking as appropriate.

After consideration of the comments received, we are finalizing the use of low-income insured days proxy to determine Factor 3 for Puerto Rico hospitals for FY 2022.

(b) Methodology for Calculating Factor 3 for FY 2022

As we explained in the FY 2022 IPPS/LTCH PPS proposed rule (86 FR 25454), for purposes of determining Factor 3 for FY 2022, we are applying the methodology adopted in the FY 2021 IPPS/LTCH PPS final rule. Specifically, we are applying the following policies: (1) the merger policies that were initially adopted in the FY 2015 IPPS/LTCH PPS final rule (79 FR 50021), as modified in the FY 2021 IPPS/LTCH PPS final rule to incorporate the use of a multiplier to account for merger effective date; (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, as modified in the FY 2021 IPPS/LTCH PPS final rule, for the rare case where a hospital has a cost report that starts in one fiscal year and spans the entirety of the following fiscal year, such that the hospital has no cost report for that subsequent fiscal year, of using the cost report that spans both fiscal years for the latter fiscal year; (4) the new hospital

policy, as modified in the FY 2020 IPPS/LTCH PPS final rule; (5) the newly merged hospital policy; and (6) 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.

Comment: A commenter noted that CMS' policy of annualizing the data for the longest cost report period for a hospital in a fiscal year disadvantages providers who have undergone a change in ownership (CHOW). According to the commenter, there are cases when the hospital undergoes a CHOW in the later part of their 12-month cost reporting period, and in such cases the first stub-period's uncompensated care costs would be annualized for purposes of calculating Factor 3. The commenter notes that this approach poses a problem because the annualized stub-period would understate the hospital's uncompensated care as compared to the full combination of pre- and post- CHOW reports due to "significant presumptive charity write-offs occurring in the last month of the 2nd stub period [not annualized]." The commenter provided an example of such case, where a hospital's Factor 3 was understated by 20 percent under the current policy of annualizing the longest cost report.

The commenter also noted that the use of annualization may understate or overstate a hospital's uncompensated care due to seasonal fluctuations, and that in the event of a CHOW, such annualization would not be needed if both cost report stubs, pre- and post- CHOW, would equal 12 months. The commenter also provided analysis that demonstrated significant uncompensated care payment impacts, both positive and negative, due to the current policy (only the longest cost report stub would be utilized for hospitals that underwent a CHOW) as compared to combining stub-period cost reports that account for all 12 months.

To address these issues, the commenter requested that CMS utilize a combined stub-period cost report that accounts for all 12 months of uncompensated care data for hospitals that have undergone CHOWs but maintained their fiscal year ends when calculating Factor 3.

Response: We thank the commenter for expressing their concerns and suggestions. We believe that the current policy of using the longest cost report available in a fiscal year for a hospital and annualizing its data meets, in practice, the policy goals of adjusting uncompensated care costs for purposes of the Factor 3 calculation. In addition, given that CHOWs are not mergers, we do not, at this time, consider it necessary to combine data across cost reports. There are also inherent issues in combining cost reports for CHOW hospitals in that, as the commenter noted, the true annual volume of uncompensated care for some providers could be overestimated or underestimated as a result. We believe CHOWs and the timing of charity write-offs are hospital business decisions. We also note that we did not propose any changes to the policy for providers with multiple cost reports; and, we would want to collect additional input and suggestions from stakeholders before considering making any potential modifications or refinements to the current policy for hospitals with multiple cost reports in future rulemaking. Therefore, we are not adopting the commenter's recommendation at this time.

- New Hospital for Purposes of Factor 3

We are continuing to apply the new hospital policy that was initially adopted in the FY 2020 IPPS/LTCH PPS final rule to determine Factor 3 for new hospitals that do not have an FY 2018 cost report to use in the Factor 3 calculation (that is, hospitals with CCNs established on or after October 1, 2018). In the FY 2020 IPPS/LTCH PPS final rule, we modified the new hospital policy that was initially adopted in the FY 2014 IPPS/LTCH PPS final rule (78 FR 50643) and continued to apply through FY 2019 (83 FR 41417). Under this modified policy, if a new hospital has a preliminary projection of being eligible for DSH payments based on its most recent available disproportionate patient percentage, it may receive interim empirically justified DSH payments. However, new hospitals will not receive interim uncompensated care payments during FY 2022 because we will have no FY 2018 uncompensated care data on which to determine what those interim payments should be. 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 2022 cost report. If the hospital is ultimately determined to be eligible for Medicare DSH payments for FY 2022, 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 2022 cost report, and the denominator is the sum of the uncompensated care costs reported on Worksheet S–10 of the FY 2018 cost reports for all DSH-eligible hospitals. This denominator will 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.

- Newly Merged Hospitals

We are continuing 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 will 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 will continue to treat newly merged hospitals in a similar manner to new hospitals, such that the newly merged hospital's final uncompensated care payment will be determined at cost report settlement. The numerator of the newly merged hospital's Factor 3 will 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, the data from the newly merged hospital's cost report will be annualized for purposes of the Factor 3 calculation.

Consistent with past policy, interim uncompensated care payments for the newly merged hospital will be based only on the data for the surviving hospital's CCN available at the time of the development of the final rule. In other words, the eligibility of a newly merged hospital to receive interim uncompensated care payments for FY 2022 and the amount of any interim uncompensated care payments, will be based only on the FY 2018 cost report available for the surviving CCN at the time the final rule is developed. However, at cost report settlement, we will determine the newly merged hospital's final uncompensated care payment based on the uncompensated care costs reported on its FY 2022 cost report. That is, we will 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 2022 cost report.

Comment: A commenter supported the policy of making interim uncompensated care payments to newly merged hospitals based on the surviving hospital's cost report for FY 2018 and then determining the final uncompensated care payment for these hospitals at cost report settlement based on the FY 2022 cost report for the merged hospital. The commenter also supported the continuation of our current policy for determining uncompensated care payments for new hospitals.

Response: We appreciate the commenter's support for these policies. We are not making modifications to our existing policy regarding newly merged hospitals.

- 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). Consistent with the process for

trimming CCRs used in the FY 2021 IPPS/LTCH PPS final rule (85 FR 58831 and 58832), we apply the following steps to determine the applicable CCR:

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

Step 2: For FY 2018 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 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 will be selected.) The ceiling is 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 2018 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.

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 2018 greater than 3 standard deviations above the national geometric mean for that fiscal year (that is, the CCR "ceiling"). For both the proposed rule and this final rule, the statewide average CCR was applied to 10 hospitals, of which 3 hospitals had FY 2018 Worksheet S–10 data.

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

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

- Uncompensated Care Data Trim Methodology

In the FY 2022 IPPS/LTCH PPS proposed rule (86 FR 25455), 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, under the trim methodology for potentially aberrant UCC that was included as part of the methodology for purposes of determining Factor 3 in the FY 2021 final rule (85 FR 58832), if the hospital's uncompensated care costs for FY 2018 are an extremely high ratio (greater than 50 percent) of its total operating costs, we will determine the ratio of uncompensated care costs to the hospital's total operating costs from another available cost report, and 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 hospital's FY 2018 cost report is determined to include potentially aberrant data, data from the FY 2019 cost report will be used for the ratio calculation. Thus, the hospital's uncompensated care costs for FY 2018 will be trimmed by multiplying its FY 2018 total operating costs by the ratio of uncompensated care costs to total operating costs from the hospital's FY 2019 cost report to calculate an estimate of the hospital's uncompensated care costs for FY 2018 for purposes of determining Factor 3 for FY 2022.

As we noted in the proposed rule, we have audited the FY 2018 Worksheet S-10 data for a number of hospitals. 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, consistent with the policy that was adopted in the FY 2021 IPPS/LTCH PPS final rule, it is unnecessary to apply the trim methodology for these audited hospitals.

In addition to the existing UCC trim methodology, we proposed to apply a new trim specific to certain hospitals that do not have audited FY 2018 Worksheet S-10 data. In the FY 2022 IPPS/LTCH PPS proposed rule (86 FR 25455), we noted that in rare cases, hospitals that are not currently projected to be DSH eligible and that do not have audited Worksheet S-10 data may have a potentially aberrant amount of insured patients' charity care costs (line 23 column 2). We proposed to use a threshold of three standard deviations from the mean ratio of insured patients' charity care costs to total uncompensated care costs (line 23 column 2 divided by line 30) and a dollar threshold of $7 million, which is the median total uncompensated care cost reported on FY 2018 cost reports for hospitals that are projected to be DSH eligible, excluding IHS and Tribal hospitals and Puerto Rico hospitals. Therefore, for FY 2022, we proposed that in the rare case that a hospital's insured patients' charity care costs are greater than $7 million and the ratio of the hospital's cost of insured patient charity care (line 23 column 2) to total uncompensated care costs (line 30) is greater than 60 percent (rounded from 58 percent), we would exclude the hospital from the prospective Factor 3 calculation. This proposed trim would only impact hospitals that are not currently projected to be DSH eligible; and therefore, are not part of the calculation of the denominator of Factor 3, which includes only uncompensated care costs for projected DSH eligible hospitals. If a hospital would be trimmed under both the existing UCC trim methodology and this proposed new trim, we proposed to apply this new trim in place of the existing UCC trim methodology. We explained that we believe the proposed new trim more appropriately addresses potentially aberrant insured patient charity care costs compared to the existing trim, because the existing trim is based solely on the ratio of total uncompensated care costs to total operating costs and does not consider the level of insured patients' charity care costs.

In addition, we also proposed that, for the hospitals that would be subject to the proposed trim, if the hospital is ultimately determined to be DSH eligible at cost report settlement, then the MAC would calculate a Factor 3 after reviewing the uncompensated care information reported

on Worksheet S-10 of the hospital's FY 2022 cost report. We believe if a hospital subject to this proposed trim is ultimately determined to be DSH eligible at cost report settlement, its uncompensated care payment should be calculated only after the hospital's reporting of insured charity care costs on its FY 2022 Worksheet S-10 has been reviewed. We note that this approach is comparable to the policy for new hospitals for which we cannot calculate a prospective Factor 3 because they do not have Worksheet S-10 data for the relevant fiscal year.

Comment: A commenter supported the policy not to adjust uncompensated care costs from hospitals that have been audited and found in compliance by their MAC and encouraged CMS to work with MACs to distinguish between inaccurate and legitimate values. Another commenter supported the proposed policy of trimming potentially aberrant charity care cost data from hospitals that are currently not projected to be DSH eligible and do not have audited FY 2018 Worksheet S-10 data by excluding the hospital from the prospective Factor 3 calculation.

Response: We appreciate the commenters' support. We reiterate our continued efforts to work with the MACs to improve the accuracy of the uncompensated care costs reported on Worksheet S-10. After consideration of the comments received, we are finalizing the proposed policy for trimming potentially aberrant charity care costs for hospitals that are not projected to be DSH eligible and that do not have an audited Worksheet S-10 for FY 2018.

- Summary of Methodology

In summary, for FY 2022, we will 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) 2018 cost reports. (Alternatively, in the rare case when the provider has no FFY 2018 cost report because the cost report for the previous Federal fiscal year spanned the FFY 2018 time period, the previous Federal fiscal year cost report will 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.

Step 4: Calculate Factor 3 for IHS and Tribal hospitals and Puerto Rico hospitals that have a cost report for 2013 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 2018 cost report data (from Step 1, 2 or 3). New hospitals and 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)(*9*) to reflect the methodology for computing Factor 3 for FY 2022 for IHS and Tribal hospitals and for Puerto Rico hospitals that have a 2013 cost report. We also proposed to make a conforming change to limit the reference to Puerto Rico hospitals in paragraph (g)(1)(iii)(C)(8) to those Puerto Rico hospitals that have a cost report for 2013.

Comment: A couple of commenters 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. These commenters did not object to CMS using prospective estimates, derived from the best data available, to calculate interim payments for uncompensated care costs. However, the commenters stated that interim payments should be subject to later reconciliation based on estimates derived from actual data from the applicable Federal fiscal year. The commenters also noted that not all FY 2018 Worksheet S– 10 cost reports were audited

and that the use of a blend of audited and unaudited data would be arbitrary and inconsistent with the statutory requirements. These same commenters also expressed the need for meaningful engagement on concerns raised in the rulemaking process and stated that the statutory preclusion of review 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 continue to 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 prospectively. 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 2022 IPPS/LTCH PPS proposed rule included a detailed discussion of the methodology for calculating Factor 3 for FY 2022 and the data that would be used. All proposed modifications to the methodology that was adopted in the FY 2021 IPPS/LTCH PPS final rule (85 FR 58833) for FY 2021 and subsequent fiscal years were discussed in detail in the proposed rule, and we solicited comments on the proposed methodology for FY 2022 (86 FR 25457). 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 to submit comments, and we have considered those comments in determining our final policies for FY 2022.

Comment: A commenter urged CMS not to use the HCRIS extract from March 2021 to calculate the final Factor 3 for FY 2022, mentioning that in the proposed rule, the agency indicated it would consider using a later HCRIS extract for the purposes of calculating the final Factor 3 for the FY 2022 IPPS/LTCH PPS final rule. According to the commenter, it would be appropriate to use a later HCRIS extract considering the "last minute" Worksheet S-10 audit adjustments made by the MACs, which were made beyond CMS' expected timeframe of using a December 2020 HCRIS extract for the FY 2022 proposed rule and a March HCRIS extract for the FY 2022 final rule. The commenter asserted that due to these delayed adjustments, they did not have ample time to scrutinize the data. Additionally, the commenter provided their analysis regarding reports with changes to Worksheet S-10 data between the December 2020 and March 2021 HCRIS extracts; specifically, the commenter stated that 15 percent of hospitals eligible for uncompensated care payments received a negative adjustment, which the commenter believed warrants using more recent, accurate cost report extract

Response: We appreciate the commenter's concerns regarding the HCRIS extract proposed for use in the FY 2022 IPPS/LTCH final rule. We also agree with the commenter's recommendation on using a later HCRIS extract for calculating Factor 3 for FY 2022. We recognize that at the time of the March HCRIS extract, MACs were resolving inadvertent report upload discrepancies, which delayed the availability of the most up-to-date reports with audited Worksheet S-10 data for some hospitals. For example, there was a delay in uploading some amended reports to incorporate Worksheet S-10 audit results. Therefore, we are finalizing the use of the June 30 HCRIS extract to calculate Factor 3 for this FY 2022 IPPS/LTCH PPS final rule. We believe on balance this is the best available data for purposes of calculating Factor 3 for FY 2022.

Additionally, 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, but the corrected uncompensated care cost data were inadvertently omitted from the June 30, 2021 extract of the HCRIS), we used the corrected version of the report after confirming the appropriate report version with the applicable MAC.

We note that for purposes of Factor 3 calculations for future years, we still intend to use the most recent data available for the applicable rulemaking, which generally means the respective December HCRIS extract for purposes of 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 proposed rule for the applicable fiscal year and that the respective HCRIS extract public use files, which are posted on the CMS website quarterly, would 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 2022 IPPS/LTCH PPS proposed rule, we intend to use the respective March HCRIS for future final rules, because we believe audited Worksheet S-10 data from FY 2019 reports will be available before the development of the FY 2023 proposed rule and final rule.

(c) Per Discharge Amount of Interim Uncompensated Care Payments

Since FY 2014, we have made interim uncompensated care payments during the fiscal year on a per discharge basis. We have used a 3-year average of the number of discharges for a hospital to produce an estimate of the amount of the hospital's uncompensated care payment per discharge. Specifically, the hospital's total uncompensated care payment amount for the applicable fiscal year, is divided by the hospital's historical 3-year average of discharges computed using the most recent available data to determine the uncompensated care payment per discharge for that fiscal year.

We proposed to modify this calculation for FY 2022 to be based on the average of FY 2018 and FY 2019 historical discharge data, rather than a 3-year average that includes data from

FY 2018, FY 2019, and FY 2020. We explained our belief that computing a 3-year average with the FY 2020 discharge data would underestimate discharges, due to the decrease in discharges during the pandemic. Under the proposed approach, the resulting 2-year average of discharges would be used to calculate the per discharge payment amount that will be used to make interim uncompensated care payments to each projected DSH eligible hospital during FY 2022. The interim uncompensated care payments made to a 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 the FY 2021 IPPS/LTCH PPS final rule (85 FR 58833 and 58834), we finalized a voluntary process through which a hospital may submit a request to its 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 must 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 is 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.

Under the policy we finalized in the FY 2021 IPPS/LTCH PPS final rule, 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 historical average number of discharges is lower than hospital's projected FY 2022 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 will be made is 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. If the MAC determines it would be appropriate to reduce the interim Medicare uncompensated care payment per discharge amount, that updated amount will be used for purposes of the outlier payment calculation for the remainder of the Federal fiscal year. We refer readers to the Addendum to the proposed rule for a more detailed discussion of the steps for determining the operating and capital Federal payment rate and the outlier payment calculation. 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, any change to the per discharge uncompensated care payment amount will not change how the total uncompensated care payment amount will be reconciled at cost report settlement.

Comment: Several commenters expressed support for the proposed policy of using the average of FY 2018 and FY 2019 discharge data, rather than a three-year average, which would also include FY 2020 discharges. The commenters agreed that this change is appropriate in light of the COVID-19 PHE.

Response: We thank commenters for their support. We are finalizing our proposal to modify the methodology used to estimate a hospital's average number of discharges to be based on FY 2018 and FY 2019 historical discharge data, rather than a 3-year average that includes data from FY 2018, FY 2019, and FY 2020. We agree with commenters that including FY 2020 discharge data would underestimate discharges due to the effects of the COVID-19 PHE.

Comment: A commenter recommended that CMS apply a growth factor to the claims average in the DSH Public Use File, in order to account for the growth in Medicare eligible population due to aging baby boomers. According to the commenter, the growth factor could be based on "calculating the growth in Part A fee-for-service average monthly enrollment" from

Congressional Budget Office (CBO) published estimates. Based on the commenter's calculations, the growth factor could be 1.08, which is the quotient from dividing 66 million Part A beneficiaries in 2022 by 61 million in 2019.

The commenter also requested that the agency establish a limit on the estimated per claim amount due to exorbitant per-claim values of up to $117,599. The commenter stated that such amounts could produce significantly high coinsurance charges for Medicare Advantage (MA) beneficiaries if services are rendered out-of-network, which could exceed an MA beneficiary's out-of-pocket maximum. The commenter also mentioned that the approach of determining per-discharge uncompensated care payments based on Medicare patient volumes rather than uncompensated care volumes produces cash flow swings for hospitals with significant amounts of uncompensated care but low Medicare patient volumes, resulting in interim uncompensated care payments that do not reflect the actual costs incurred by the hospital.

Regarding CMS' current policy under which hospitals may request that their MAC adjust per-claim payment amounts, the commenter stated that it seemed unlikely that hospitals would want to request a lower or zero per-claim uncompensated care payments because of inherent incentives to maximize their cash flow. To this end, the commenter recommends that CMS place a cap on the amount of the per-discharge interim uncompensated care payments "within the range of $5,233 - $10,466, which represents a range of one to two standard deviations of the Estimated Per Claim Amounts for all qualifying hospitals."

Response: We thank the commenter for sharing their concerns and feedback. We continue to believe that allowing hospitals the opportunity of voluntarily requesting a decrease to the per-discharge amount of interim uncompensated care payments may facilitate greater payment predictability throughout the year and limit recoupment of overpayments as part of cost report settlement. Regarding the commenter's other suggestions, such as applying a growth factor as part of the per discharge calculation, we may consider this input for any potential modifications or refinements to our policy for determining interim uncompensated care

payments in future rulemaking; however, at this time, we are not adopting any changes to the current policy.

(d) 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 2022 (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. However, we note that a Factor 3 will not be published for the hospitals that are subject to the new trim we are adopting in this final rule, which is similar to the approach for new hospitals, which also do not have a Factor 3 published. Although we noted in the FY2022 IPPS/LTCH PPS proposed rule, that if more recent data become available, then we would use such data in the final rule, at the time of development of this final rule, the FY 2019 SSI ratios were not available. Accordingly, for purposes of this final rule, we computed Factor 3 for IHS 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. In the DSH uncompensated care supplemental data file, we list new hospitals and the 8 hospitals that are subject to the new trim, with a N/A in the Factor 3 column. We note that two of the hospitals that were projected to be subject to the trim in the proposed rule, are no longer participating in the Medicare program.

Hospitals had 60 days from the date of public display of the FY 2022 IPPS/LTCH PPS proposed rule in the **Federal Register** 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 raising issues 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 that we would address comments related to mergers and/or reporting upload discrepancies submitted to the CMS DSH inbox as appropriate in the table and the supplemental data file that we publish on the CMS website in conjunction with the publication of the FY 2022 IPPS/LTCH PPS final rule. All other comments submitted in response to our proposed policies for determining uncompensated care payments for FY 2022 must have been submitted in one of three ways found in the ADDRESSES section of the proposed rule before the close of the comment period in order to be assured consideration. In addition, this CMS DSH inbox is not intended for Worksheet S–10 audit process related emails, which should be directed to the MACs.

For FY 2022, we again proposed that hospitals would have 15 business days from the date of public display of the FY 2022 IPPS/LTCH PPS final rule in the **Federal Register** 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 arising from this review would be posted on the CMS website and would be effective beginning October 1, 2021. We also explained that we continue to believe that hospitals 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. Hospitals do not enter into mergers without advanced planning. A hospital can inform CMS during the comment period for the proposed rule regarding any merger activity not reflected in supplemental file published in conjunction with the proposed rule. As discussed in an earlier section of this final rule, we also stated that we

expected to use data from the March 2021 HCRIS extract for the FY 2022 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 for the proposed rule. However, we noted that we might consider using more recent data that may become available after March 2021, but before the final rule for the purpose of calculating the final Factor 3s for the FY 2022 IPPS/LTCH PPS final rule. In the event that there are any remaining merger updates and/or upload discrepancies after the final rule, the 15 business days from the date of public display of the FY 2022 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.

Comment: A commenter notified CMS that in reviewing the DSH Supplemental File for the FY 2022 proposed rule, their merger was not listed and only one hospital was included in the file. The commenter requested assurance that the merger would appear in the FY 2022 final rule. Another commenter reported what it deemed to be an erroneous adjustment made by a MAC to copayment amounts that had been written off and had been reported on the Worksheet S-10 as charity care. The commenter urged CMS to reverse the adjustment made by the MAC to their uncompensated care costs for purposes of calculating Factor 3 in FY 2022.

Response: We appreciate the commenters' diligence in checking that their own reports and data were properly processed in DSH Public Use File. We have accounted for the merger and the report discrepancies identified by commenters, as appropriate, in the development of the DSH supplemental data file published in conjunction with this FY 2022 IPPS/LTCH PPS 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 merger notification, we thank the commenter for informing CMS of the merger activity not reflected in supplemental file published in conjunction with the proposed rule. Regarding the commenter

reporting a disagreement related to Worksheet S-10 audit adjustments, as explained in the proposed rule, inquiries related to the audit process should be directed to the respective MAC.

After consideration of the comments received, we are finalizing our proposal to afford hospitals 15 business days from the public display of this FY 2022 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. We also note that the historical FY 2018 cost reports are publicly available on a quarterly basis on the CMS website for analysis and additional review of cost report data, separate from the supplemental data file published with this final rule.

F. Counting Days Associated With Section 1115 Demonstration Projects in the Medicaid Fraction

We continue to review the large number of comments on the proposed revision to the regulation relating to the treatment of section 1115 waiver days for purposes of the DSH adjustment. Due to the number and nature of the comments that we received on our proposal, we intend to address the public comments in a separate document. We refer individuals interested in reviewing the background information and the discussion regarding these policies to the FY 2022 IPPS/LTCH PPS proposed rule (86 FR 25457 through 25459).