costs of subsection (d) hospitals in the United States. Contrary to the commenters' assertion, we also have authority to implement the proposed budget neutrality adjustment associated with the proposed cap as an adjustment under section 1886(d)(5)(I)(i) of the Act, which similarly gives the Secretary broad authority to provide by regulation for such other exceptions and adjustments to such payment amounts under subsection (d) as the Secretary deems appropriate. Furthermore, our past transition policies involving a 5 percent cap on wage index decreases implemented in a budget neutral manner did not result in wage index volatility, and we expect the same for the overall budget neutrality adjustments associated with the permanent cap policy.

Comment: MedPAC supported the proposal to cap wage index decreases at 5 percent, but suggested also applying a cap to increases of more than 5 percent.

Response: We appreciate MedPAC's suggestion that the cap on wage index changes of more than 5 percent should also be applied to increases in the wage index. However, as we discussed in the proposed rule, one purpose of the proposed policy is to help mitigate the significant negative impacts of certain wage index changes. As we discussed in the proposed rule, we believe applying a 5-percent cap on all wage index decreases would support increased predictability about IPPS payments for hospitals in the upcoming fiscal year, enabling them to more effectively budget and plan their operations. That is, we proposed to cap decreases because we believe that a hospital would be able to more effectively budget and plan when there is predictability about its expected minimum level of IPPS payments in the upcoming fiscal year. We did not propose to limit wage index increases because we do not believe such a policy is needed to enable hospitals to more effectively budget and plan their operations. Therefore, we believe it is appropriate for hospitals that experience an increase in their wage index value to receive that wage index value.

Comment: A commenter suggested that if CMS discontinues the low wage index hospital policy, hospitals that benefitted in the prior year from that policy should not be subject to a 5 percent cap on any decreases.

Response: We appreciate the commenter's suggestion. As discussed in section III. G. 4 of this final rule, CMS is continuing the low wage index hospital policy for FY 2023.

Comment: A commenter did not support CMS's proposed policy approach to the wage index cap policy with regard to newly opened hospitals. While the commenter stated they understand the rationale for CMS's policy approach, they expressed concerns that it will create inequity in Medicare payments for hospitals within the same market. The commenter encouraged CMS to apply the same area wage index value for new and existing hospitals under this policy.

Response: We understand the commenter's concern, but we do not believe the scenario they are alluding to (that is, a labor market where existing hospitals are receiving the cap, and new hospitals are not) would neither be common nor require additional consideration. We believe that on an ongoing basis, relatively few hospitals would receive the cap, and even fewer would receive the cap in consecutive years. As of this final rule, there will be 126 hospitals receiving the cap in FY 2023, and only 12 that will receive a cap increase of greater than 5 percent. Therefore, any potential difference in the wage index value hospitals in the same labor market area receive would likely be minimal and temporary. We proposed to examine the effects of this policy on an ongoing basis to assess whether it effectively and appropriately accomplishes the goal of increasing predictability and stability in IPPS payments, and may reevaluate this issue in the future. However, at this time, we do not believe that creating a policy modification for hospitals that were not assigned a wage index in the prior year is necessary.

After consideration of the public comments we received, for the reasons discussed in this final rule and in the proposed rule, we are finalizing as proposed, without modification, our wage index cap policy and the associated budget neutrality adjustment. We will apply a 5-percent cap on any decrease to a hospital's wage index from its wage index in the prior FY, regardless of the circumstances causing the decline. A hospital's wage index for FY 2023 will not be less than 95 percent of its final wage index for FY 2022, and for subsequent years, a hospital's wage index will not be less than 95 percent of its final wage index for the prior FY. For example, a hospital that received a wage index of 1.0000 on September 30, 2022 could not receive a wage index of less than 0.9500 for FY 2023. If a hospital's prior FY wage index is calculated with the application of the 5-percent cap, the following year's wage index will not be less than 95 percent of the hospital's capped wage index in the prior FY. Except for newly opened hospitals, we will apply the cap for a FY using the final wage index applicable to the hospital on the last day of the prior FY. A newly opened hospital would be paid the wage index for the area in which it is geographically located for its first full or partial fiscal year, and it would not receive a cap for that first year because it would not have been assigned a wage index in the prior year.

We are adding a new paragraph at 42 CFR 412.64(h)(7) to state that beginning with fiscal year 2023, if CMS determines that a hospital's wage index value for a fiscal year would decrease by more than 5 percent as compared to the hospital's wage index value for the prior fiscal year, CMS limits the decrease to 5 percent for the fiscal year.

We will apply the cap in a budget neutral manner through a national adjustment to the standardized amount each fiscal year. Specifically, we will apply a budget neutrality adjustment to ensure that estimated aggregate payments under our wage index cap policy for hospitals that would have a decrease in their wage indexes for the upcoming fiscal year of more than 5 percent would equal what estimated aggregate payments would have been without the wage index cap policy. We note that the budget neutrality adjustment has been updated based on the final rule data. We refer readers to the Addendum of this final rule for further information regarding the budget neutrality calculations.

IV. Payment Adjustment for Medicare Disproportionate Share Hospitals (DSHs) for FY 2023 (§ 412.106)

A. 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.

DSH Eligibility	Qualifying Criteria
Statutory Formula	A hospital that has a disproportionate patient percentage equal to or exceeding 15 percent, may qualify for the Medicare DSH adjustment. We refer readers to 42 CFR 412.106 for the specific eligibility criteria and payment formulas.
"Pickle Method"	A hospital that is located in an urban area and has 100 or more beds may qualify to 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

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.

Since FY 2014, section 1886(r) of the Act has required that hospitals that are eligible for DSH payments under section 1886(d)(5)(F) of the Act receive 2 separately calculated payments:

Medicare DSH Payment	An empirically justified DSH payment equal to 25% of the amount determined under the statutory formula in section 1886(d)(5)(F) of the Act for Medicare DSH payments
Medicare DSH Uncompensated Care Payment	An uncompensated care payment determined as the product of the 3 factors, as discussed in this section.

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.'' In brief, the uncompensated care payment for an individual hospital is determined as the product of the following 3 factors:

Factor 1	75% of the total amount of DSH payments that would otherwise made under section 1886(d)(5)(F) of the Act.
Factor 2	1 minus the percent change in the percent of individuals who are uninsured (minus 0.2 percentage point for FYs 2018 and 2019). For FY 2020 and after, there is no additional reduction.
Factor 3	The hospital's uncompensated care amount relative to the uncompensated care amount for all DSH hospitals expressed as a percentage.

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 was established through the exercise of the Secretary's discretion in implementing the capital IPPS under section 1886(g)(1)(A) of the Act.

Finally, section 1886(r)(3) of the Act provides that there shall be no administrative or judicial review under section 1869, section 1878, or otherwise of any estimate of the Secretary for purposes of determining the factors described in section 1886(r)(2) of the Act or of any period selected by the Secretary for the purpose of determining those factors. Therefore, there is no administrative or judicial review of the estimates developed for purposes of applying the three factors used to determine uncompensated care payments, or the periods selected in order to develop such estimates.

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

As 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). For the proposed rule, we estimated DSH status for all hospitals using the most recent available SSI ratios and information from the most recent available Provider Specific File. We noted FY 2019 SSI ratios available on the CMS website were the most recent available SSI ratios at the time of developing the proposed rule. If more recent data on DSH eligibility become available before the final rule, we stated that we would use such data in the final rule. For this FY 2023 IPPS/LTCH PPS final rule, the FY 2020 SSI ratios were available at the time of developing this final rule. Our final determination of a hospital's eligibility for uncompensated care payments will be based on the hospital's actual DSH status at cost report settlement for FY 2023.

In the FY 2014 IPPS/LTCH PPS final rule (78 FR 50622) and in the rulemaking for subsequent fiscal years, we have specified our policies for several specific classes of hospitals within the scope of section 1886(r) of the Act. In the FY 2023 IPPS/LTCH PPS proposed rule, we discussed our specific policies regarding eligibility to receive empirically justified Medicare DSH payments and uncompensated care payments for FY 2023 with respect to the following hospitals.

Eligible hospitals include the following:

- *Subsection (d) Puerto Rico hospitals* that are eligible for DSH payments also are eligible to receive empirically justified Medicare DSH payments and uncompensated care payments under section 1886(r) of the Act (78 FR 50623 and 79 FR 50006).
- *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. 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 interim empirically justified Medicare DSH and interim uncompensated care payments as we do for all other IPPS hospitals.

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. We note that there has not been legislation at the time of development of this final rule that would extend the MDH program beyond September 30, 2022. However, if the MDH program were to be extended beyond its current expiration date, similar to how it was extended under the Bipartisan Budget Act of 2018, we would continue to make a determination concerning an MDH's eligibility for interim uncompensated care payments based on the hospital's estimated DSH status for the applicable 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. The BPCI Advanced Model's final performance year will end on December 31, 2023. 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. We refer the reader 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.

Ineligible hospitals include the following:

- *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 2023, 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.
- *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 Public Law 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 Public Law 114–255 also required a solicitation for applications for additional hospitals to participate in the demonstration program. The period of performance for this 5-year extension period ended December 31, 2021. The Consolidated Appropriations Act, 2021 (Pub. L. 116–260) amended section 410A of Public Law 108–173 to extend the Rural Community Hospital Demonstration Program for an additional 5-year period. The period of participation for the last hospital in the demonstration under this most recent legislative authorization would extend until June 30, 2028, as outlined in section V.K. of the preamble of this final rule. 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. At the time of development of this final rule, we believe 26 hospitals may participate in the demonstration program at the start of FY 2023.

We received no comments on our 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 2023. Our final determination of a hospital's eligibility for uncompensated care payments for FY 2023 will continue to be based on the hospital's actual DSH status at cost report settlement for the payment year.

C. Empirically Justified Medicare DSH Payments

As we have discussed earlier, section 1886(r)(1) of the Act requires the Secretary to pay 25 percent of the amount of the 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 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 *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2014-Transmittals-Items/R5P240.html*.

We received public comments that were outside the scope of this proposed rule. Many of these comments related to structural changes to the DSH program. For example, a commenter recommended creating new Conditions of Participation and Conditions of Coverage related to the DSH program. Because we consider these public comments to be outside the scope of the proposed rule, we are not addressing them in this final rule.

D. 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 2022, and our final policies for FY 2023.

1. Calculation of Factor 1 for FY 2023

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 2023 IPPS/LTCH PPS proposed rule (87 FR 28383 through 28385), in order to determine Factor 1 in the uncompensated care payment formula for FY 2023, 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 section 1886(r)(1) of the Act. Consistent with the policy that has applied in previous years, we proposed that these estimates would not be revised or updated subsequent to the publication of our final projections in this FY 2023 IPPS/LTCH PPS final rule.

Therefore, in order to determine the two elements of proposed Factor 1 for FY 2023 (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 2020 through FY 2023 were discussed in the proposed rule in the table titled ''Factors Applied for FY 2020 through FY 2023 to Estimate Medicare DSH Expenditures Using FY 2019 Baseline'' (87 FR 28384).

For purposes of calculating the proposed Factor 1 and modeling the impact of the FY 2023 IPPS/LTCH PPS proposed rule, we used the Office of the Actuary's January 2022 Medicare DSH estimates, which were based on data from the September 2021 update of the Medicare Hospital Cost Report Information System (HCRIS) and the FY 2022 IPPS/LTCH PPS final rule IPPS Impact File, published in conjunction with the publication of the FY 2022 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 2022 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 2022 Medicare DSH estimates. The 26 hospitals that are anticipated to participate in the Rural Community Hospital Demonstration Program in FY 2023 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 uncompensated care payments.

For the proposed rule, using the data sources as previously discussed, the Office of the Actuary's January 2022 estimate of Medicare DSH payments for FY 2023 without regard to the application of section 1886(r)(1) of the Act, was approximately $13.266 billion. Therefore, also based on the January 2022 estimate, the estimate of empirically justified Medicare DSH payments for FY 2023, with the application of section 1886(r)(1) of the Act, was approximately $3.316 billion (or 25 percent of the total amount of estimated Medicare DSH payments for FY 2023). 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 2023 would be $9,949,258,556.56, which was equal to 75 percent of the total amount of estimated Medicare DSH payments for FY 2023 ($13,266 million minus $3,316 million). In the FY 2023 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 2023 IPPS/LTCH PPS final rule.

As we noted in the FY 2023 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 the 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 that 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.

For a general overview of the principal steps involved in projecting future inpatient costs and utilization, we refer readers to the ''2021 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* 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 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, so that the data is available to replicate CMS' DSH calculation and comment sufficiently in future years.

In particular, commenters requested further explanation regarding the estimate of the ''Other'' factor used to estimate Medicare DSH payments. Commenters noted that the rule did not discuss why the ''Other'' factor varies so much over successive rule making cycles.

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 provided sufficient details nor an explanation of the treatment of Medicaid expansions in the calculation for Factor 1.

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 2023 IPPS/LTCH PPS proposed rule and in this section of this final rule, we have been and continue to be transparent about the methodology and data used to estimate Factor 1. Regarding the commenters who reference the Administrative Procedure Act, we note that, under the Administrative Procedure Act, a proposed rule is required to include either the terms or substance of the proposed rule or a description of the subjects and issues involved. In this case, the FY 2023 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 interested parties 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 the proposed rules are generally consistent with the economic assumptions and actuarial analyses used to develop the President's Budget estimates under current law, and the Factor 1 estimates for the final rule are generally consistent with those used for the Midsession Review of the President's Budget. As we have in the past, for additional information on the development of the President's Budget, we refer readers to the Office of Management and Budget website at: *https://www.whitehouse.gov/omb/budget*. For additional information on the specific economic assumptions used in the Midsession Review of the President's FY 2023 Budget, we refer readers to the ''Midsession Review of the President's FY 2023 Budget'' also available on the Office of Management and Budget website at: *https://www.whitehouse.gov/omb/budget*. We recognize that our reliance on the economic assumptions and actuarial analyses used to develop the President's Budget and the Midsession Review of the President's Budget in estimating Factor 1 has an impact on hospitals, health systems, and other impacted parties who wish to replicate the Factor 1 calculation, such as modeling the relevant Medicare Part A portion of the budget. Yet, we believe commenters are able to meaningfully comment on our proposed estimate of Factor 1 without replicating the budget.

For a general overview of the principal steps involved in projecting future inpatient costs and utilization, we refer readers to the ''2022 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds'' available on the CMS website at: *https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/index.html* under ''Downloads.'' 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/files/document/2018-report.pdf* for a discussion of general issues regarding Medicaid projections. Additionally, as described in more detail later in this section, in the FY 2023 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 Medicaid and CHIP expansion.

For further information on our assumptions regarding Medicaid expansion in the Factor 1 calculation, we provide a discussion of more recent estimates and assumptions regarding the Medicaid expansion as part of the discussion of the final Factor 1 for FY 2023. This discussion also incorporates the estimated impact of the COVID–19 public health emergency (PHE.)

Comment: Many commenters questioned the proposed rule's estimate of the ''Discharge'' component of the Factor 1 calculation. Commenters requested clarity on the Factor 1 calculations, which assume small increases in discharge volume for FY 2022 and FY 2023.

Commenters noted that they are seeing trends that indicate that FY 2022 and FY 2023 discharge volumes, even though lower than pre-PHE levels, will continue to increase substantially. Some commenters urged CMS to reflect the same assumptions that the agency described in the ''April 2022 Announcement of CY 2023 Medicare Advantage Capitation Rates and Part C and Part D Payment Policies,'' where the agency made assumptions that Medicare ''utilization will begin to rebound.'' Other commenters referenced a Kaufman Hall study, and stated that adjusted national patient volume has increased by 18 percent from February 2022 to March 2022. A commenter referred to their own analysis of Medicare-Fee-For-service (FFS) claims data from the Chronic Condition Warehouse (CCW), which indicated that non-COVID–19 inpatient hospital discharge volume increased 22 percent from February to March 2022. Other commenters provided anecdotal data from their own hospitals and service regions that show continued sustained volumes in 2022. These commenters urged CMS to carefully monitor changes in discharge volume when estimating Factor 1.

Commenters also urged CMS to use a later update to the claims data to capture more of the increases in utilization that are anticipated for FY 2022. Commenters noted that the ''Discharge'' factor used by the OACT in estimating DSH expenditures was based on the December 2021 update of the MedPAR file, which includes data impacted by the PHE from FY 2021 and the first three months of FY 2022. Some commenters requested that CMS adjust the data used in the Factor 1 calculation for COVID–19 PHE impacts while others suggested that CMS exclude data from the latter parts of CY 2021 and early CY

2022. Other commenters urged CMS to consider excluding FY 2020 and FY 2021 discharges from the FY 2023 Factor 1 calculation, as data from those years include atypical trends in Medicare discharges due to the COVID–19 PHE.

Commenters pointed out that omitting FY 2020 and FY 2021 data would be consistent with CMS' exclusion of FY 2020 data in setting FY 2022 payment rates and the agency's proposal to exclude FY 2020 data from the per-discharge calculation in the FY 2023 IPPS/LTCH PPS proposed rule. Further, some commenters noted that the completion factor CMS used to estimate discharge volumes for FY 2021 and FY 2022 may not fully account for discharges due to billing delays as a result of PHE-related staffing shortages.

Finally, two commenters requested that for the FY 2024 IPPS/LTCH PPS proposed rule, CMS consider using the latest available data for the factors used to estimate Medicare DSH expenditures for purposes of calculating Factor 1 to avoid as much change in the estimate of Factor 1 between the proposed and final rules for FY 2024.

Some commenters also raised concerns about the ''Case Mix'' update factor used in the proposed FY 2023 Factor 1 calculation. Commenters stated that the proposed ''Case Mix'' update factor underestimates the complexity of patients returning to seek care following postponement or deferral of care during the COVID–19 PHE. Commenters also stated that CMS was using assumptions that are inconsistent with those that were used to develop the 2023 Medicare Advantage capitation payments, where the agency indicated an expectation that utilization will rebound in 2022 and finalized a risk score increase of 3.5 percentage points with the underlying assumption that patients put off seeking medical care throughout the PHE. Other commenters cited data from Kaufman Hall that indicate that hospitals are beginning to see more complex patients as shown by a nearly 5 percent increase in the average hospital length of stay in 2022 as compared to 2021.

Response: We thank the commenters for their input on the impact of the COVID–19 PHE on the factors used to estimate DSH payments for FY 2023. In updating our estimate of Factor 1 for this final rule, we considered, as appropriate, the same set of factors that we used in the proposed rule, which reflects the impact of the COVID–19 PHE. We then updated estimates for the ''Discharges'' and ''Case Mix'' factors to incorporate the latest available data. 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 2023 in this section of the rule.

Regarding the comments requesting that we exclude and/or mitigate the impacts of the COVID–19 PHE when estimating Factor 1 for FY 2023, we note that the statute specifies that Factor 1 is based on the amount of disproportionate share payments that would otherwise be made to subsection (d) hospitals 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 PHE on DSH payments during FY 2023.

We also note that, with regard to the commenters' questions and concerns about the use of completion factors to adjust preliminary data, OACT assumed a discharge completion factor of 0 percent for FY 2020 and 0 percent for FY 2021. We believe these assumptions are consistent with historical patterns of completion factors that have been determined for discharges and appropriately account for incomplete claims data. We do not believe that excluding data from certain periods is necessary to estimate DSH payments during FY 2023 for purposes of the Factor 1 calculation, as required by the statute.

Regarding the comments requesting that CMS apply the same assumptions the agency made when setting Medicare Advantage payment rates, we note that Medicare Advantage and Medicare FFS are distinct programs. Accordingly, the estimates for the ''Discharges'' and ''Case Mix'' factors used to estimate Medicare DSH expenditures incorporate OACT's analyses of ''Discharges'' and ''Case Mix'' using only claims from the Medicare FFS program rather than claims from the Medicare Advantage program.

In response to commenters' request that CMS use the latest available estimates of historical data to avoid as much change in the DSH Factor 1 estimate between the proposed and final rules for FY 2024, we believe that the use of the most recent available data at the time of the proposed and final rulemaking is appropriate to calculate Factor 1 and consistent with our approach in previous rulemakings. In this final rule, OACT has updated the estimate of Factor 1 with more recent economic assumptions and actuarial analyses.

Comment: Commenters expressed concern regarding the proposed $800 million reduction in the amount available to make uncompensated care payments in FY 2023 compared to FY 2022. Commenters stated that this reduction does not align with CMS' objective to reduce healthcare inequities as the reduction disproportionately impacts safety-net hospitals, which primarily serve low income and vulnerable populations.

Response: The statute specifies that Factor 1 is based on the amount of disproportionate share payments that would otherwise be made to subsection (d) hospitals for the fiscal year. Because our estimate of Factor 1 is based on the best available data regarding the amount of DSH payments that would otherwise be made during FY 2023, we believe it is appropriate and consistent with the requirements of the statute.

After consideration of the public comments we received, we are finalizing, as proposed, the methodology for calculating Factor 1 for FY 2023. We discuss the resulting Factor 1 amount for FY 2023 in this section. For this final rule, OACT used the most recently submitted Medicare cost report data from the March 31, 2022, 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 2023 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 June 2022 OACT estimate for Medicare DSH payments for FY 2023, without regard to the application of section 1886(r)(1) of the Act, was approximately $13.949 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 this June 2022 estimate, the estimate of empirically justified Medicare DSH payments for FY 2023, with the application of section 1886(r)(1) of the Act, was approximately $3.487 billion (or 25 percent of the total amount of estimated Medicare DSH payments for FY 2023). 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 2023 is $10,461,731,029.40, which is equal to 75 percent of the total amount of estimated Medicare DSH payments for FY 2023 ($13,948,974,705.87 minus $3,487,243,676.47).

The Office of the Actuary's estimates of DSH expenditures for FY 2023 for this final rule began with a baseline of $13.814 billion in Medicare DSH

expenditures for FY 2019. The following table shows the factors applied to update this baseline through the current estimate for FY 2023:

Factors Applied for FY 2020 through FY 2023 to Estimate Medicare DSH Expenditures Using FY 2019 Baseline						
FY	Update	Discharges	Case-Mix	Other	Total	Estimated DSH Payment (in billions)*
2020	1.031	0.862	1.038	0.9952	0.9181	12.682
2021	1.029	0.939	1.029	1.0174	1.0116	12.829
2022	1.025	0.986	0.99	1.0235	1.0241	13.138
2023	1.043	1.050	0.99	0.9793	1.0618	13.949

*Rounded.

In this table, the discharges column shows the changes in the number of Medicare fee-for-service (FFS) inpatient hospital discharges. The discharge figures for FY 2020 and FY 2021 are based on Medicare claims data that have been adjusted by a completion factor to account for incomplete claims data. We note that these claims data reflect the impact of the pandemic. The discharge figure for FY 2022 is based on preliminary data. The discharge figure for FY 2023 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 2023 incorporate the actual impact and estimated future 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 2020 and FY 2021 are based on actual claims data adjusted by a completion factor. We note that these claims data reflect the impact of the pandemic. The case-mix figure for FY 2022 is based on preliminary data and the case-mix figure for FY 2023 is an assumption based on recent trends recovering back to the long-term trend. The case-mix factor figures for FY 2020 to FY 2023 incorporate the actual impact and estimated future impact of the COVID–19 pandemic. The ''Other'' column shows the increase in other factors that contribute to the Medicare DSH estimates. These factors include the difference between the total inpatient hospital discharges and the IPPS discharges, and various adjustments to the payment rates that have been included over the years but are not reflected in the other columns (such as the change in rates for the 2-midnight stay policy and the 20 percent add-on for COVID–19 discharges). In addition, the ''Other'' column includes a factor for the estimated changes in Medicaid enrollment. We note that this factor also includes the estimated impacts on Medicaid enrollment from the COVID–19 pandemic. We note that, based on the most recent available data, Medicaid enrollment is estimated to change as follows: 2.0 percent in FY 2020, 9.5 percent in FY 2021, 4.2 percent in FY 2022, and -5.7 percent in FY 2023. In the future, the assumptions regarding Medicaid enrollment may change based on actual enrollment in the States.

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/MedicaidReport*. We note that, in developing their estimates of the effect of Medicaid enrollment increases on Medicare DSH expenditures, our actuaries have assumed that the increases in the number of Medicaid enrollees result in increases in Medicare DSH expenditures at the same rate as historical relationships have shown. In the future, the assumption about the average per-capita expenditures of Medicaid beneficiaries who enrolled due to the COVID–19 pandemic may change, given that the pandemic is still ongoing.

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
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
2023	4.1	0	-0.3	0.5	4.3

Note: All numbers are the inpatient hospital updates for the applicable year. 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 2023.

2. Calculation of Factor 2 for FY 2023

(a) 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. We proposed to use a methodology similar to the one that was used in FY 2018 through FY 2022 to determine Factor 2 for FY 2023.

In the FY 2018 IPPS/LTCH PPS final rule (82 FR 38197 and 38198), we explained that we determined the data source for the rate of uninsurance that, on balance, best meets all of our considerations and is consistent with the statutory requirement that the estimate of the rate of uninsurance be based on data from the Census Bureau or other sources the Secretary determines appropriate, 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*. We note that the NHEA estimates of uninsurance are for the total resident-based U.S. population, including all people who usually reside in the 50 States or the District of Columbia, but excluding individuals 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 the U.S., plus a small (typically less that 0.2 percent of population) adjustment to reflect Census undercounts. Thus, the NHEA estimates of uninsurance are for U.S. residents of all ages and are not limited to a specific age cohort, such as the population under the age of 65. 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 U.S. that influence uncompensated care for hospitals than an estimate that reflects only legal residents.

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 2020, 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 2020. 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 *https://www.census.gov/programs-surveys/cps.html*.) The enhanced CPS, available from SHADAC (available at *http://datacenter.shadac.org*) accounts for changes in the CPS methodology over time. OACT further adjusts the enhanced CPS for an estimated undercount of Medicaid enrollees (a population that is often not fully captured in surveys that include Medicaid enrollees due to a perceived stigma associated with being enrolled in the Medicaid program or confusion about the source of their health insurance).

To estimate the number of uninsured individuals for 2010 through 2018, OACT extrapolates from the 2009 CPS data through 2018 using data from the National Health Interview Survey (NHIS). The NHIS is one of the major data collection programs of the National Center for Health Statistics (NCHS), which is part of the Centers for Disease Control and Prevention (CDC). The 2019 estimate was extrapolated using the 2019/2018 trend from the American Community Survey (ACS). The 2020 estimate was extrapolated using the 2020/2018 trend from the CPS as published by the Census Bureau. The U.S. Census Bureau is the data collection agent for the NHIS, the ACS, and the CPS. 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/*. For information regarding the data collection issues regarding the 2020 ACS, we refer readers to the Census Bureau's website at *https://www.census.gov/newsroom/blogs/random-samplings/2021/10/pandemic-impact-on-2020-acs-1-year-data.html*. Since the 2020 ACS data

were not available, the ACS data were not used for purposes of estimating the number of uninsured individuals for 2020.

The next metrics needed to compute Factor 2 for FY 2023 are projections of the rate of uninsurance in both CY 2022 and CY 2023. On an annual basis, OACT projects enrollment and spending trends for the coming 10-year period. The most recent projections are for 2021 through 2030. 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 projected growth rates in enrollment for Medicare, Medicaid, and CHIP are developed to be consistent with the 2021 Medicare Trustees Report, updated where possible with more recent data. Projected rates of growth in enrollment for private health insurance and the uninsured are based largely on OACT's econometric models, which rely on a set of macroeconomic assumptions that are generally based on the 2021 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*.

(b) Factor 2 for FY 2023

As discussed in the FY 2023 IPPS/LTCH PPS proposed rule, 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 2022 and 2023 is 8.9 percent and 9.3 percent, respectively. As required by section 1886(r)(2)(B)(ii) of the Act, the Chief Actuary of CMS has certified these estimates. We refer readers to OACT's Memorandum on Certification of Rates of Uninsured prepared for the FY 2023 IPPS/LTCH PPS proposed rule for further details on the methodology and assumptions that were used in the projection of these rates of uninsurance.[213]

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 2023.

The OACT certified the estimate of the rate of uninsurance for FY 2023 determined using this weighted average approach to be reasonable and appropriate for purposes of section 1886(r)(2)(B)(ii) of the Act. In the FY 2023 IPPS/LTCH PPS proposed rule, we noted that we might also consider the use of more recent data that might become available for purposes of estimating the rates of uninsurance used in the calculation of the final Factor 2 for FY 2023. In the proposed rule, we outlined the calculation of the proposed Factor 2 for FY 2023 as follows:

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

Percent of individuals without insurance for CY 2022: 8.9 percent.

Percent of individuals without insurance for CY 2023: 9.3 percent.

Percent of individuals without insurance for FY 2023 (0.25 times 0.089) + (0.75 times 0.093): 9.2 percent.

$1 - |((0.092 - 0.14)/0.14)| = 1 - 0.3429 = 0.6571$ (65.71 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 2023 would be 65.71 percent.

The proposed FY 2023 uncompensated care amount was $9,949,258,556.56 * 0.6571 = $6,537,657,797.52.

Proposed FY 2023 Uncompensated Care Amount	$6,537,657,797.52

In addition, we stated that it had recently come to our attention that the provision of the regulations that addresses Factor 2 inadvertently omits any reference to the statutory methodology in section 1886(r)(2)(B)(ii) of the Act for determining Factor 2 for FY 2018 and subsequent fiscal years. Accordingly, we proposed a technical change to the regulation at § 412.106 to update paragraph (g)(1)(ii) to reflect the statutory requirements governing the determination of Factor 2 for FY 2018 and subsequent fiscal years. We explained that we have determined Factor 2 for FY 2018 through FY 2022 consistent with the plain language of section 1886(r)(2)(B)(ii) of the Act; therefore, this proposed technical change is intended merely to update our regulations to reflect the methodology for determining Factor 2 that has applied since FY 2018 and will continue to apply for FY 2023 and subsequent fiscal years.

We invited public comments on our proposed Factor 2 for FY 2023 and on the proposed technical change to the regulation at § 412.106(g)(1)(ii).

Comment: The majority of commenters discussed Factor 2 in the context of the impact of the temporary COVID–19 PHE provisions, such as the Families First Coronavirus Response Act's Medicaid continuous coverage requirement and the American Rescue Plan's Marketplace enhanced premium tax credits, on the uninsured rate for FY 2023. Commenters questioned CMS' estimates for the FY 2023 uninsured rate and urged the Office of the Actuary (OACT) to update its estimate of Factor 2 to account for the projected increases in the number of uninsured as the COVID–19 PHE provisions expire. Many commenters questioned CMS' estimated decrease in the uninsured rate from 9.6 percent in the FY 2022 IPPS/LTCH PPS final rule to 9.2 percent in FY 2023 IPPS/LTCH PPS proposed rule and stated that they expect increases in the uninsured rates in their communities. Further, many commenters noted that the proposed decrease of $800 million in uncompensated care payments from the level in FY 2022 was likely, in part, driven by the projected uninsured rate. To that end, commenters cited CMS'

[213] OACT Memorandum on Certification of Rates of Uninsured. March 28, 2022. Available at: *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInPatientPPS/dsh.html.*

statement in the proposed rule that the agency might consider more recent data that may have become available for the calculation of Factor 2 in FY 2023 and urged CMS to use more recent data sources to account for the anticipated increase in the uninsured rate. One commenter requested that CMS consider temporarily changing its methodology for calculating Factor 2 to better account for individuals who may lose their healthcare coverage when various PHE provisions expire and noted that CMS has taken similar approaches in other Medicare payment areas affected by the COVID–19 PHE.

Many commenters referenced various data sources and analyses, such as the Kaiser Family Foundation, the Urban Institute, and HHS' Assistant Secretary for Planning and Evaluation (ASPE) which project 5 to 16 million individuals will lose their Medicaid coverage and another 3 million additional individuals will lose their marketplace insurance in FY 2023. Accordingly, these commenters requested that CMS increase Factor 2 to reflect the anticipated increase in the uninsured population as suggested by these sources. In addition, one commenter requested that CMS exclude FY 2020 and FY 2021 data when calculating the uninsured rate to eliminate any irregularities due to the COVID–19 PHE.

Response: We thank the commenters for their input regarding the estimate of Factor 2 for FY 2023 included in the proposed rule. In response to commenters who requested that we update the estimate of the FY 2023 uninsured rate to fully consider any changes due to the anticipated expirations of the PHE and the Marketplace premium tax credits, we note that the rate of uninsurance used for the calculation of Factor 2 for the proposed rule, as well as for this final rule, reflects CMS' latest analyses and projections. The projected enrollment trends across all insurance types, as well as for the uninsured, take into account the expected impacts of current law including the termination of the Families First Coronavirus Response Act's continuous coverage provision for Medicaid (assumed to expire when the PHE ends in 2022 and to be accompanied by a one-year transition of disenrollments from the program for those no longer eligible) and the conclusion of the enhanced Marketplace premium tax credits. We believe that this NHEA projection, on balance, best meets all of our considerations for ensuring that the data source that underlies the Factor 2 calculation of the uninsured rate meets the statutory requirement that the estimate be based on data sources that the Secretary determines to be appropriate, is certified by CMS' Chief Actuary, and provides a reasonable estimate for the rate of uninsurance that is available in conjunction with the IPPS rulemaking cycle. We refer readers to OACT's memorandum ''Certification of Rates of Uninsured'' and OACT's report titled ''Projections of National Health Expenditure: Methodology and Model Specification'' for further details on the methodology and updated assumptions used in the calculation of the projected uninsured rate.

We disagree with comments' suggestions that we exclude FY 2020 and FY 2021 data, or any data from the COVID–19 PHE period, for purposes of calculating the uninsured rate for FY 2023. The projections that underlie the FY 2023 Factor 2 calculation should take into consideration, and include, those elements that are expected to influence health insurance enrollment trends during FY 2023, and the resulting rate of uninsured, including the unique circumstance associated with the COVID–19 pandemic.

Comment: Some commenters suggested that CMS use a different estimate of the uninsured rate to calculate Factor 2 for FY 2023, while acknowledging that OACT accounted for the expiration of the COVID–19 PHE provisions in its uninsurance estimates. These commenters indicated that because the uninsured percent change serves as a proxy for the change in the amount of uncompensated care that hospitals provide, it would be appropriate for CMS to apply a case-mix adjuster to the uninsured rate for FY 2023 to account for the rise in resources that will be used by hospitals to provide care to uninsured individuals who may have delayed their care during the COVID–19 PHE.

A few commenters requested that CMS maintain the same level of uncompensated care funding as in FY 2022 ($7.2 billion) while another commenter requested that CMS consider delaying any proposed changes to the uncompensated care payment calculations until analyses can be performed to determine the actual uninsured rate and related costs following the end of the COVID–19 PHE. Other commenters urged CMS to be transparent in its calculation of Factor 2 and how it accounts for Medicaid expansion populations, while others urged CMS to be transparent regarding the data sources used for calculating Factor 2 and the assumptions behind the uninsured rate.

Response: Regarding the commenters that requested modifications to the uninsured rate, such as multiplying by a case-mix factor, we note that these recommendations would not be consistent with the statutory requirements in section 1886(r)(2)(B)(ii). The statute explicitly specifies that Factor 2 be based on 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 and the percent of individuals who were uninsured in the most recent period for which data are available.

Regarding the comments recommending that CMS maintain total uncompensated care payments at the FY 2022 level or delay any changes to the amount available to make uncompensated care payments, we believe estimating Factor 2 based on the best available data regarding the expected rate of uninsurance in FY 2023 is appropriate and consistent with the statute.

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 2023 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 projected rates of uninsurance for CY 2022 and CY 2023, which account for the effects of the COVID–19 PHE and any legislative impacts arising from the end of the COVID–19 PHE on insurance coverage. Section 1886(r)(2)(B)(ii) of the Act permits us to use a data source other than 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 used to estimate Factor 2 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. Accordingly, we continue to believe that it is appropriate to calculate Factor 2 based on the NHEA-based projection of the FY 2023 rate of uninsurance as we proposed.

After consideration of the public comments we received, we are finalizing, as proposed, the Factor 2 calculation for FY 2023. The estimates of the percent of uninsured individuals were produced and certified by OACT for purposes of the FY 2023 IPPS proposed rule. Those published CY and

estimated FY rates continue to be the latest available projections.

The calculation of the final Factor 2 for FY 2023 using a weighted average of OACT's certified estimates is as follows:

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

Percent of individuals without insurance for CY 2022: 8.9 percent.

Percent of individuals without insurance for CY 2023: 9.3 percent.

Percent of individuals without insurance for FY 2023 (0.25 times 0.089) + (0.75 times 0.093): 9.2 percent.

$1 - |((0.092 - 0.14)/0.14)| = 1 - 0.3429 = 0.6571$ (65.71 percent).

Therefore, the final Factor 2 for FY 2023 is 65.71 percent. The final FY 2023 uncompensated care amount is $10,461,731,029.40* 0.6571 = $6,874,403,459.42.

Final FY 2023 Uncompensated Care Amount	$ 6,874,403,459.42

We did not receive any comments on our proposed technical change to the regulation governing the calculation of Factor 2. We are finalizing the update to § 412.106(g)(1)(ii), as proposed.

3. Calculation of Proposed Factor 3 for FY 2023

(a) 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. We refer readers to the FY 2018 IPPS/LTCH PPS final rule (82 FR 38201 through 38203) for a complete discussion of these analyses.

In the FY 2018 IPPS/LTCH PPS final rule (82 FR 38206), we 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. 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, which reflected the most recent available information regarding these hospitals' low-income insured days before any expansion of Medicaid (82 FR 38208 through 38212).

In the FY 2019 IPPS/LTCH PPS final rule (83 FR 41414), we stated that 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 were currently available for FY 2014 or FY 2015 that would be a better proxy for the costs of subsection (d) hospitals for treating individuals who are uninsured. 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 3 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.

In the FY 2020 IPPS/LTCH PPS final rule (84 FR 42368), we finalized our proposal to use a single year of audited 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 more recent 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 explained that mixing audited and unaudited data for individual hospitals by averaging multiple years of data could potentially lead to a less smooth result. We also 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 would be 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 of ''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). 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). This is the same definition that we initially adopted in the FY 2018 IPPS/LTCH PPS final rule. 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 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. For further information, we refer the readers to the following website. *https://www.reginfo.gov/public/do/PRAViewDocument?ref_nbr=202206-0938-017.*

(b) Background on the Methodology Used To Calculate Factor 3 for FY 2022

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 2022 IPPS/LTCH PPS final rule, we continued to apply 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; (3) the modified new hospital policy that was finalized in the FY 2020 IPPS/LTCH PPS final rule; (4) the new merger policy adopted in the FY 2021 IPPS/LTCH PPS final rule that accounts for the merger effective date; and (5) 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. We discuss these policies in greater detail in this section.

In the FY 2022 IPPS/LTCH PPS final rule (86 FR 45244), 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 at 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 cost report for the applicable fiscal year. That is, for FY 2022, we will revise the numerator of Factor 3 for a newly merged hospital to reflect the uncompensated care costs reported on the newly merged hospital's FY 2022 cost report.

In FY 2022 IPPS/LTCH PPS final rule, 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 originally adopted in 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. We also applied the modified policy that was adopted in the FY 2021 IPPS/LTCH PPS final rule (85 FR 58829) 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 2022 IPPS/LTCH PPS final rule (86 FR 25454), we continued the modified new hospital policy for new hospitals that do not have data for the cost reporting period(s) used in the Factor 3 calculation (that is, the most recent cost reporting year for which audits have been conducted). 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 during the fiscal year. However, because these hospitals do not have a cost report for the cost reporting period used in the Factor 3 calculation and the projection of eligibility for DSH payments is still preliminary, we are unable to calculate a prospective Factor 3 for these hospitals and they do not receive interim uncompensated care payments. The MAC will make a final determination concerning whether the hospital is eligible to receive Medicare DSH payments for the fiscal year at cost report settlement. Thus, for FY 2022, if a new 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 same denominator that was used in the prospective Factor 3 calculation for FY 2022 (that is, the sum of the uncompensated care costs reported on Worksheet S–10 of the FY 2018 cost reports for all DSH-eligible hospitals).

In the FY 2022 IPPS/LTCH PPS final rule, we continued the new merger policy that accounts for the merger effective date, that was originally adopted in FY 2021. To more accurately estimate uncompensated care costs (UCC) for the hospitals involved in a merger when the merger effective date occurs partway through the surviving hospital's cost reporting period, we apply 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 the UCC of the surviving hospital for purposes of determining Factor 3 for the merged hospital.

In the FY 2022 IPPS/LTCH PPS final rule (86 FR 25454 and 25455), 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 (86 FR 45245). However, because we audit the Worksheet S–10 data for a number of hospitals, we no longer believe it is necessary to apply the trim methodology for hospitals whose cost report has been audited. Accordingly, for FY 2022, we continued the policy adopted in FY 2021 under which we exclude hospitals that were part of the audits for the fiscal year used in the Factor 3 calculation from the trim

methodology for potentially aberrant UCC. We also continued to apply a modified trim methodology for all-inclusive rate providers (AIRPs) with potentially aberrant UCC (86 FR 45235). 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 cost report for the most recent cost reporting year for which audits have been conducted, we 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 addition, in the FY 2022 IPPS/LTCH PPS final rule (86 FR 45245 and 452456), we finalized an alternative trim specific to hospitals that are not projected to be DSH-eligible and that do not have audited FY 2018 Worksheet S–10 data for use in determining Factor 3. We explained that we believe this new alternative 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. Specifically, we finalized that, for the hospitals that would be subject to the 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 stated that we believe if a hospital subject to this 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 noted 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.

In the FY 2022 IPPS/LTCH PPS final rule (86 FR 45242 and 45243), 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 2022 IPPS/LTCH PPS final rule (86 FR 45236) for a discussion of the approach that we continued to apply in FY 2022 to determine Factor 3 for new Puerto Rico hospitals. In brief, Puerto Rico hospitals that do not have a FY 2013 cost report were 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.

Consistent with the policy adopted in the FY 2021 IPPS/LTCH PPS final rule and codified in the regulations at § 412.106(g)(8) for subsequent fiscal years, in the FY 2022 IPPS/LTCH PPS final 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.

Therefore, for FY 2022, we applied the following methodology to compute Factor 3 for each hospital:

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.

In the FY 2022 IPPS/LTCH PPS final rule, we amended 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 finalized a conforming change to limit the reference to Puerto Rico hospitals in § 412.106(g)(1)(iii)(C)(*8*) to those Puerto Rico hospitals that have a cost report for 2013.

(c) Changes to the Methodology for Calculating Factor 3 for FY 2023 and Subsequent Fiscal Years

As described in the FY 2022 IPPS/LTCH PPS final rule, commenters expressed concerns that the use of only 1 year of data to determine Factor 3 would lead to significant variations in year-to-year uncompensated care payments. Some stakeholders recommended the use of 2 years of historical Worksheet S–10 data (86 FR 45237). In the FY 2022 IPPS/LTCH PPS final rule, we stated that we would consider using multiple years of data when the vast majority of providers have been audited for more than 1 fiscal year under the revised reporting instructions. The audits of FY 2019 cost reports began in 2021 and those audited reports were available in time for the development of the FY 2023 IPPS/LTCH PPS proposed rule. Feedback from previous audits and lessons learned were incorporated into the audit process for the FY 2019 reports.

In consideration of the comments discussed in the FY 2022 IPPS/LTCH PPS final rule, in the FY 2023 IPPS/LTCH PPS proposed rule, we proposed to determine Factor 3 for FY 2023 using the average of the audited FY 2018 and audited FY 2019 reports. We stated our belief that this proposal would address concerns from stakeholders regarding

year-to-year fluctuations in uncompensated care payments. In addition, taking into consideration the comments recommending that CMS transition to the use of 3 years of audited data, we indicated that we expect FY 2024 will be the first year that 3 years of audited data will be available at the time of rulemaking. Accordingly, for FY 2024 and subsequent fiscal years, we proposed to use a 3-year average of the uncompensated care data from the 3 most recent fiscal years for which audited data are available to determine Factor 3. Specifically, for FY 2024, we would expect to use data from FY 2018, FY 2019, and FY 2020 reports to calculate uncompensated care payments. In other words, for each of the 3 most recent fiscal years for which audited data are available at the time of rulemaking for the applicable fiscal year, we would divide a hospital's uncompensated care costs for the fiscal year by the estimated total uncompensated care costs of all DSH hospitals for that fiscal year. Then, we would calculate an average of those proportions to determine the hospital's Factor 3 for the applicable Federal fiscal year. We explained that we believe the proposed approach is generally consistent with our past practice of using the most recent single year of audited data from the Worksheet S–10, while also addressing commenters' concerns regarding year-to-year fluctuations in uncompensated care payments. Consistent with the approach that we followed when multiple years of data were previously used in the Factor 3 methodology, we proposed that if a hospital does not have data for all 3 years used in the Factor 3 calculation, we would determine Factor 3 based on an average of the hospital's available data.

We invited public comments on our proposed methodology for calculating Factor 3 for FY 2023 and subsequent fiscal years, including, but not limited to, our proposal to use the most recent audited Worksheet S–10 data from FY 2018 and FY 2019 cost reports to determine Factor 3 for FY 2023, and our proposal to begin using the 3 most recent years of audited Worksheet S–10 data starting in FY 2024.

Comment: Commenters expressed continued support for the general use of Worksheet S–10 data to calculate each hospital's share of uncompensated care costs in FY 2023 and future years. Some commenters also noted their long-standing support for using audited Worksheet S–10 data to promote an accurate and consistent calculation of uncompensated care costs. One commenter, who supported using Worksheet S–10 data, stressed the importance of ongoing refinements to the audit process to ensure data accuracy, while another recommended that CMS regularly assess and identify unusual or irregular trends in the data.

Response: We appreciate the support for our proposal to use Worksheet S–10 data to calculate Factor 3 for FY 2023 and future years. Regarding those comments that noted the importance of ongoing refinements to the Worksheet S–10 audit process, we 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. As noted in the FY 2023 IPPS/LTCH PPS proposed rule, we believe that, on balance, Worksheet S–10 data are the best available data to use for calculating Factor 3 for FY 2023 and subsequent fiscal years.

Comment: An overwhelming majority of commenters expressed support for CMS' proposal to calculate Factor 3 for FY 2023 based on a two-year average of audited FY 2018 and FY 2019 Worksheet S–10 data. These commenters also expressed support for the proposal to transition to use of a three-year average of the most recent available audited Worksheet S–10 data for FY 2024 and subsequent fiscal years. Some commenters explicitly stated that they agreed with CMS that the use of only one year of data could lead to undue fluctuations in year-to-year uncompensated care payments. Supporters of these proposals also specified several benefits from the use of a multi-year average of Worksheet S–10 data, such as minimizing year-to-year volatility, ensuring stability in future uncompensated care payments, and mitigating the effect of irregular trends and data anomalies, like the COVID–19 PHE. One commenter suggested that CMS consider working with hospitals in future years to ensure that Worksheet S–10 data from the COVID–19 PHE period is reported appropriately, given the PHE's significant impact on the utilization of healthcare services. To this end, one commenter recommended that CMS consider incorporating FY 2020 Worksheet S–10 data into the multi-year average for FY 2023 once the data has been audited, as this approach would be more reflective of current healthcare costs.

In contrast, only a handful of commenters expressed opposition to using a two-year average of audited FY 2018 and FY 2019 Worksheet S–10 data for FY 2023 and a three-year average of Worksheet S–10 data to calculate uncompensated care payments moving forward. One commenter indicated that using a three-year average to calculate FY 2024 uncompensated care payments would dilute the impact of the COVID–19 PHE on the FY 2020 Worksheet S–10 data. This commenter asserted that using a multi-year average would benefit hospitals that received the highest amount of Health Resources & Services Administration (HRSA) subsidies and hospitals with lower uncompensated care costs, while harming hospitals with higher uncompensated care cost data in FY 2020. The commenter also requested that CMS provide expedited procedures for reopening and correcting Worksheet S–10 data for the cost reporting periods that will be used to calculate uncompensated care payments in FY 2024 and future years.

Another commenter noted that the FY 2022 methodology based on one year of audited Worksheet S–10 data was adequate and should not be modified to a multi-year average, indicating that inconsistencies in the methodology used to calculate Factor 3 from year to year add a further burden to hospitals' ability to understand and predict their uncompensated care payments. This commenter also urged CMS to reexamine the continued use of FY 2018 Worksheet S–10 data to determine payments for FY 2022, FY 2023, and FY 2024, as it may benefit hospitals that provided elevated levels of uncompensated care in FY 2018, and negatively impact those that provided less uncompensated care.

Finally, some commenters suggested alternative approaches to calculating Factor 3 of the uncompensated care payment calculation that went beyond the blending of historical Worksheet S–10 data for multiple fiscal years.

Response: We thank commenters who expressed their support for our proposal to use a two-year average of audited FY 2018 and FY 2019 Worksheet S–10 data to determine each hospital's share of uncompensated care costs in FY 2023 and to use of a 3-year average of audited Worksheet S–10 data starting in FY 2024. As explained in the FY 2023 IPPS/LTCH PPS proposed rule, we believe that using a multi-year average of Worksheet S–10 data will provide assurance that hospitals' uncompensated care payments remain stable and predictable and will not be subject to unpredictable swings and anomalies in a hospital's uncompensated care costs.

We also believe that our proposal to use multiple years of data is responsive to past commenters' requests for the use of multiple years of audited data. We disagree with the commenter who stated

that modifying the uncompensated care payment methodology to use multiple years of data would put undue burden on a hospital's ability to understand, budget, and forecast as we believe that our proposal to use a multi-year average of Worksheet S–10 data to determine Factor 3 for FY 2023 and subsequent fiscal years is responsive to past recommendations for smoothing fluctuations.

In relation to the commenter who noted that the multi-year average will benefit hospitals that received the highest amount of HRSA subsidies and hospitals with lower uncompensated care costs, we note that cost reporting data from the COVID–19 PHE time period is not yet available to be analyzed. We believe it would be premature to attempt, in this rulemaking, to modify the methodology for determining uncompensated care payments for a future year, specifically to address the potential impact of the PHE-related subsidies.

In response to the request that we provide expedited procedures for reopening and correcting Worksheet S–10 data that will be used in the Factor 3 calculation, we note that we do not intend to establish fixed timelines for reopenings across MACs, so we can retain the flexibility to use our limited audit resources to address and prioritize audit needs across all CMS programs each year. However, we note that MACs work closely with hospitals regarding reopenings.

Regarding commenters' suggestions for alternative approaches to calculating Factor 3 beyond the previously considered methodological concepts for the blending of historical Worksheet S–10 data, we appreciate commenters' input and note that we may consider these suggestions in future rulemaking.

After consideration of the comments received, we are finalizing our proposal to use a two-year average of audited FY 2018 and FY 2019 Worksheet S–10 data to calculate Factor 3 in FY 2023 and a three-year average of audited data from the most recent fiscal years for which audited data are available to determine Factor 3 in subsequent years. We also note that the number of audited hospitals continues to increase year to year and, as a result, we believe data from Worksheet S–10 will improve in reliability over time. However, we will continue to audit additional years of the Worksheet S–10 data and monitor the stability of uncompensated care payments as we move forward with using a multi-year average of audited Worksheet S–10 data for Factor 3 calculations.

As discussed in the FY 2023 IPPS/LTCH PPS proposed rule, we have determined Factor 3 for IHS and Tribal hospitals and Puerto Rico hospitals, based on the low-income insured days proxy for uncompensated care costs. In the FY 2022 IPPS/LTCH PPS final rule, we discussed comments we had received from IHS/Tribal hospitals and Puerto Rico hospitals about the significant challenges they face in relation to uncompensated care reporting (86 FR 45242 and 45243). For example, 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 (86 FR 45242). Another commenter expressed concerns that Puerto Rico hospitals were understating the components of uncompensated care costs, and indicated that technical education is needed to address the challenges Puerto Rico hospitals have regarding charity care and bad debt reporting, which the commenter stated would take years to address (86 FR 45243).

In the FY 2023 IPPS/LTCH PPS proposed rule, we acknowledged that to the extent commenters have identified specific challenges for IHS/Tribal hospitals and Puerto Rico hospitals in reporting uncompensated care costs on Worksheet S–10, it is possible that after a sufficient number of years these reporting challenges could be addressed. However, despite the reporting challenges described by commenters, we expressed our concern that the historical 2013-based data on low-income insured days, which has been used as an alternative to data on uncompensated care costs from the Worksheet S–10 to determine Factor 3 for IHS/Tribal hospitals and Puerto Rico hospitals, is no longer a good proxy for the costs of these hospitals in treating the uninsured, given the time that has elapsed since 2013. In 2023, this data will be 10 years old and there is no obvious way to update the information given our stated concerns surrounding the differential impact of state Medicaid expansions after 2013. In light of these concerns, we stated that we could no longer conclude that alternative data to the data on uncompensated care costs reported on Worksheet S–10 are currently available for IHS/Tribal hospitals and Puerto Rico hospitals that are a better proxy for the costs of these hospitals in treating the uninsured.

Accordingly, for FY 2023 and subsequent fiscal years, we proposed to discontinue the use of low-income insured days as a proxy for the uncompensated care costs of these hospitals and proposed to use the same data to determine Factor 3 for IHS and Tribal hospitals and Puerto Rico hospitals as for other hospitals. Specifically, for FY 2023, we would determine Factor 3 for IHS and Tribal hospitals and Puerto Rico hospitals based on the average of the uncompensated care data reported on Worksheet S–10 of their FY 2018 and FY 2019 cost reports. However, we sought comments on alternatives both to our proposal to use data on uncompensated care costs from the Worksheet S–10 to determine Factor 3 for IHS/Tribal hospitals and Puerto Rico hospitals and to the continued use of low-income insured days as a proxy for the uncompensated care costs of these hospitals. We also sought comments on how to best measure and define the uncompensated care costs associated with these hospitals that might not otherwise be captured in Factor 3 calculations based on Worksheet S–10 data. Because we recognized that our proposal to discontinue the use of the low-income insured days proxy and to rely solely on Worksheet S–10 data to calculate Factor 3 of the uncompensated care payment methodology for IHS/Tribal hospitals and Puerto Rico hospitals could result in a significant financial disruption for these hospitals, we also proposed to establish a new supplemental payment for IHS/Tribal hospitals and Puerto Rico hospitals, beginning in FY 2023. We refer readers to section IV.E. of the preamble of this final rule for a complete discussion of this proposed new supplemental payment.

Prior to the proposed rulemaking for FY 2023, CMS consulted with IHS and Tribes regarding our policies for determining uncompensated care payments. They expressed that uncompensated care payments are critical to the providers and should be maintained at their current levels, at a minimum. As we explained in the FY 2023 IPPS/LTCH PPS proposed rule, we considered this recent input along with previous input from stakeholders in the development of our proposed policies. We also welcomed additional input from stakeholders regarding the unique circumstances of IHS/Tribal hospitals and Puerto Rico hospitals and/or any mitigating factors, and noted that this input would inform our considerations about our proposal to determine Factor 3 for these hospitals using data from

Worksheet S–10 and the related proposal to establish a new supplemental payment for IHS/Tribal hospitals and Puerto Rico hospitals.

We received comments on our proposal to discontinue the use of the low-income insured days proxy and to rely solely on Worksheet S–10 data to calculate Factor 3 of the uncompensated care payment methodology for IHS/Tribal hospitals and Puerto Rico hospitals. Due to the close interrelationship between this proposal and our proposal to establish a new supplemental payment for IHS/Tribal hospitals and Puerto Rico hospitals, we discuss those comments, along with the comments received on the proposed new supplemental payment, and set forth our final policies in Section IV.E of this final rule.

For purposes of the FY 2023 proposed rule, we used the December 2021 HCRIS extract to calculate Factor 3. We noted that we intended to use the March 2022 update of HCRIS to calculate Factor 3 for the FY 2023 IPPS/LTCH PPS final rule. However, we stated that we may consider the use of more recent data that may become available after March 2022, but prior to the development of the final rule, if appropriate, for purposes of calculating the final Factor 3 for this FY 2023 IPPS/LTCH PPS final rule.

We received comments regarding the uncompensated care costs definition and Worksheet S–10 cost report instructions.

Comment: With regard to the definition of uncompensated care, several commenters urged CMS to include unreimbursed costs (shortfalls) from Medicaid in the definition of uncompensated care. Specifically, some commenters urged CMS to account for Medicaid shortfalls and incorporate Line 31 of Worksheet S–10 along with already-utilized Line 30. In contrast, one commenter agreed with CMS that Medicaid shortfalls, as currently reported on Worksheet S–10, should not be included in the estimation of uncompensated care costs. Instead, the commenter recommended that the agency revise Worksheet S–10 so data on Medicaid shortfalls better resemble actual shortfalls incurred by hospitals. The commenter further noted that such data will be increasingly useful for informational purposes as previously uninsured individuals gain access to Medicaid. Other commenters proposed incorporating social determinants of health methodologies into uncompensated care costs by including variables that describe socioeconomic disadvantage such as accounting for costs incurred by hospitals to improve access to healthy foods, transportation, health screenings, technology assistance, and similar community needs. Notably, another commenter suggested that CMS redefine uncompensated care to align with the definitions used to determine community benefit spending under the Internal Revenue Code.

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 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 first adopted in the FY 2018 IPPS/LTCH PPS final rule (82 FR 38215 through 38217) 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, key interested parties (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 for 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.

Regarding the request that we include costs incurred by hospitals to address social determinants of health in the definition of uncompensated care costs, we have consistently stated in past final rules (85 FR 58826 and 86 FR 45239) in response to similar comments that we believe 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 addressing social determinants of health, as commenters have suggested. Accordingly, we do not believe changing the calculation of uncompensated care costs is appropriate, at this time.

Comment: Commenters requested that CMS include all patient care costs when calculating the cost-to-charge ratio (CCR) used in Worksheet S–10 and urged CMS to include costs incurred for graduate medical education (GME), costs of paying provider taxes associated with Medicaid revenue, and costs of providing physician and other professional services when calculating the CCR used to determine uncompensated care costs on Worksheet S–10 in order to improve the accuracy of that CCR.

Response: As we have stated in past rules (84 FR 42378, 85 FR 58826, and 86 FR 45239) in response to similar requests that we modify the CCR used on Worksheet S–10, we continue to believe the CCR calculation that is used in Worksheet S–10 is appropriate. Regarding the request that we include GME costs, costs of paying provider taxes associated with Medicaid revenue, and costs of providing physician and other professional service when calculating CCR used in Worksheet S–10, we note that because the CCR on Line 1 of Worksheet S–10 is obtained from Worksheet C, Part I, and is also used in other IPPS rate setting contexts (such as high-cost outliers and the calculation of the MS–DRG relative weights) from which it is appropriate to exclude the costs associated with supporting GME costs and the costs of physician and professional services and costs of paying provider taxes, we remain reluctant 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.

Comment: One commenter stated that large teaching hospitals (with 100+

residents) would experience an even larger uncompensated care payment reduction, resulting in underserved and vulnerable populations having less access to transplant programs (as these programs are often operated by large teaching institutions). Another commenter expressed concern that hospitals in Medicaid non-expansion states depend greatly on uncompensated care payments for financial support, and this commenter urged CMS to work with providers and patient advocates in non-expansion states to screen patients for eligibility under either financial assistance policies or premium support under the Affordable Care Act before classifying the case as uncompensated care. The same commenter noted that the equal weighting of bad debt and charity care on the Worksheet S–10 disincentivizes hospitals from ensuring that eligible patients receive charity care, as obtaining the qualification for charity care entails long administrative processes.

Response: We thank commenters for their continued concern regarding the distribution of uncompensated care payments and the impact of reductions in uncompensated care payments on teaching hospitals. However, as stated previously, the purpose of uncompensated care payments is to provide additional payment to hospitals for treating the uninsured. Uncompensated payments are not intended to provide support for other activities that hospitals may undertake. We also note that CMS does not set charity care criteria for hospitals, and within reason, hospitals can establish their own criteria of what constitutes charity care in their financial assistance policies.

Comment: With regard to Worksheet S–10 instructions and guidance, a few commenters commended CMS for its efforts to provide clearer instructions for Worksheet S–10. A few commenters requested that CMS clarify inconsistent Worksheet S–10 instructions so that non-Medicare bad debt is not multiplied by the CCR. These commenters noted that CMS' revised instructions indicate that non-reimbursed Medicare bad debt is not reduced by the CCR, but that CMS' September 2017 transmittal states that non-Medicare bad debt should be multiplied by the CCR. One commenter indicated that such practice is inconsistent with the way non-reimbursable Medicare bad debt is treated.

Response: We appreciate commenters' concerns regarding the need for clarification of the Worksheet S–10 instructions, as well as their suggestions for revisions to improve reporting. We reiterate our commitment to continuing to work with impacted parties 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 share with their respective MAC any questions regarding clarifications of instructions, reporting, and submission deadlines.

We continue to believe that, as noted by a commenter, our efforts to refine the instructions and guidance have improved provider understanding of the Worksheet S–10 and added clarity to the instructions. We also recognize that there are continuing opportunities to further improve the accuracy and consistency of the information that is reported on the Worksheet S–10, and to the extent that commenters have raised new questions and concerns regarding the reporting requirements, we will attempt to address them through future rulemaking and/or sub-regulatory guidance and provider outreach. However, as stated in previous rules, we continue to believe that the Worksheet S–10 instructions are now sufficiently clear and allow hospitals to accurately complete Worksheet S–10s.

Regarding the commenters' request that CMS clarify whether non-Medicare bad debt is multiplied by CCR, we believe that the Worksheet S–10 instructions are clear and indicate that the CCR is multiplied by the non-Medicare bad debt amount on line 28.

Regarding the comments requesting specific structural changes to Worksheet S–10 and/or further clarification of the reporting instructions, we note that these comments fall outside the scope of this final rule. We note that a recent PRA package for hospital cost report is available at: *https://www.cms.gov/regulations-and-guidancelegislation paperworkreductionactof1995pra-listing/cms-2552-10*.

We received comments regarding Worksheet S–10 data and audits.

Comment: In relation to the accuracy of the Worksheet S–10 data, one commenter urged CMS to refine the instructions for reporting of uncompensated care costs. The commenter's recommendations included that CMS should mitigate the effect of anomalies in the cost data for the COVID–19 PHE period and that CMS should consider the redistributive effects of the COVID–19 PHE for purposes of determining uncompensated care payments in future rulemaking. One commenter recommended that CMS work with impacted providers in upcoming years to ensure that the data from the COVID–19 PHE period is properly understood and correctly reported. Another commenter urged CMS to account for the unpredictability of the COVID–19 PHE, including the emergence of new variants, in determining uncompensated care payments for future years.

Response: In regard to requests for CMS to mitigate the effect of anomalies in FY 2020 through FY 2022 cost report data and account for the unpredictability of the COVID–19 PHE in determining uncompensated care payments for future years, we note that we are finalizing the proposal to use a three-year average of the most recently audited cost report data for FY 2024 and subsequent years. Using the three-year average will smooth the variation in year-to-year uncompensated care payments and lessen the impacts of COVID–19 PHE and future unforeseen events. We also note that the calculations for Factor 1 and Factor 2 reflect the estimated impact of the COVID–19 PHE on DSH payments. Further, we anticipate that there will be less fluctuation in cost report data as the PHE disruptions on healthcare utilization fade. We will continue to monitor the impacts of the PHE and will consider this issue further in future rulemaking, as appropriate.

Comment: Some commenters commended CMS for the agency's efforts to develop and improve the audit process for Worksheet S–10 data. Specifically, one commenter commended CMS for its efforts to audit all hospitals rather than only a portion, while another commenter recommended that CMS expend all the necessary resources to continue to audit Worksheet S–10 data for all DSH eligible hospitals.

Echoing concerns expressed in previous years, commenters encouraged CMS to work with MACs to make the audit process clearer, more consistent, and more complete. The same commenters provided several recommendations, including that CMS establish a standardized process across auditors, develop uniform standards regarding information submission and acceptable documentation to meet audit requirements, develop a transparent timeframe with sufficient lead time, target specific data aspects for the audit, and develop a process for timely appeals. Specifically, one commenter recommended that all hospitals be audited using the same protocols and that having only some hospitals subject to desk reviews is inequitable. A few commenters cited the Medicare wage index audit as a model that CMS could use for Worksheet S–10 audits. One commenter suggested that CMS ensure

that Worksheet S–10 audits impose minimal burden and are equitable and uniform across hospitals. The same commenter also suggested that CMS consider making the audit process more transparent by disclosing criteria used to identify hospitals for audits and publishing audit protocols in advance to allow hospitals time and opportunity to respond to audits and address findings. Other recommendations from this commenter included that CMS should conduct audits in advance of using data for payment rate setting such that data are accurate and final, select hospitals for audits in an equitable and systematic way, and review audit findings to ensure that MACs and subcontractors are consistently performing audits according to protocols.

Response: We thank commenters for their feedback on the audits of the FY 2019 Worksheet S–10 data and their recommendations for future audits. As we have stated previously in response to comments regarding audit protocols, these are provided to the MACs in advance of the audit so as to assure consistency and timeliness in the audit process. We began auditing the FY 2019 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 2023 IPPS/LTCH PPS proposed rule. We chose to focus the audit on the FY 2019 cost reports in order to maximize the available audit resources. Similarly, as discussed in the FY 2022 IPPS/LTCH PPS final rule, we chose to focus the audits on the FY 2018 cost reports in order to maximize the available audit resources prior to the FY 2022 rulemaking. 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 2020 Worksheet S–10 data.

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, which include making changes to increase the efficiency of the audit process, building on the lessons learned in previous audit years. We will take these recommendations into consideration for future rulemaking. Regarding commenters' requests for a standard audit timeline, we do not intend to establish a fixed timeline for audits across MACs at this time such 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 collaborate with providers regarding scheduling dates during the Worksheet S–10 audit process. We also note that MACs work closely with providers to balance the time needed to complete the Worksheet S–10 audits and to minimize the burden on providers and will continue to do so.

Regarding commenters' requests that we make public the audit instructions and criteria, as we previously stated in the FY 2022 IPPS/LTCH final rule and in 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. We note that there is no requirement under either the Administrative Procedure Act or the Medicare statute that CMS establish audit protocols through notice and comment rulemaking. Rather, it is sufficient that we provide impacted parties with notice of our proposed methodology 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. Similarly, there is no requirement that we provide an opportunity for comment on the actual findings or audit disallowances determined for each hospital as these results are confidential to each hospital.

Concerning commenters' recommendations that we establish a timely review and appeals process for the Worksheet S–10 audits, we do not plan to introduce such a process at this time in order to maximize limited audit resources. However, we will continue to work with impacted parties to address their concerns regarding the accuracy and consistency of data reported on Worksheet S–10. We will also continue to work to further improve reporting through revised instructions, and will also work with MACs to ensure a more consistent audit process across providers and MACs.

Regarding commenters' recommendations that we establish a similar process to that of the wage index audits, at this point we do not plan to introduce an audit process with such a structure in order to maximize limited audit resources.

As discussed in the FY 2023 IPPS/LTCH PPS proposed rule (87 FR 28392), for purposes of determining Factor 3 for FY 2023 and subsequent fiscal years, we are continuing to apply 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 (85 FR 58828 and 58829) to incorporate the use of a multiplier to account for merger effective date; (2) the policy for hospitals with multiple cost reports, beginning in the same fiscal year, of using the longest cost report and annualizing 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 (85 FR 58829) and as further modified as proposed in the FY 2023 IPPS/LTCH PPS proposed 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 and as further modified as proposed in this section; (5) the newly merged hospital policy, with the modifications proposed in the FY 2023 IPPS/LTCH PPS proposed rule; 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, as modified as proposed in the FY 2023 IPPS/LTCH PPS proposed rule.

Because we proposed to use multiple years of cost reports to determine Factor 3 starting in FY 2023, we determined that it would also be necessary to make a further modification to the policy regarding cost reports that start in one fiscal year and span the entirety of the following fiscal year. Specifically, in the rare cases when we use a cost report that starts in one fiscal year and spans the entirety of the subsequent Federal fiscal year to determine uncompensated care costs for the subsequent Federal fiscal year, we would not use the same cost report to determine the hospital's uncompensated care costs for the earlier fiscal year. We explained that using the same cost report to determine uncompensated care costs for both fiscal years would not be consistent with our intent to smooth year-to-year variation in uncompensated care costs. As an alternative, we proposed to use the hospital's most recent prior cost report, if that cost report spans the applicable period. In other words, in determining Factor 3 for FY 2023, we would not use the same cost report to determine the hospital's uncompensated care costs for both FY 2018 and FY 2019. Rather, we would use the cost report that spans the entirety of FY 2019 to determine uncompensated care costs for FY 2019 and we would use the hospital's most recent prior cost report to determine its uncompensated care costs for FY 2018,

provided that cost report spans some portion of Federal fiscal year 2018.

We did not receive comments on this proposed modification. We are finalizing as proposed.

• *Scaling Factor*

To address the effects of the calculating Factor 3 using data from multiple fiscal years, in the FY 2023 IPPS/LTCH PPS proposed rule (87 FR 28392) we proposed to apply a scaling factor to the Factor 3 values calculated for all DSH eligible hospitals so that total uncompensated care payments to hospitals that are projected to be eligible for DSH for a fiscal year will be consistent with the estimated amount available to make uncompensated care payments for that fiscal year. Specifically, we proposed to adopt a policy under which we divide 1 (the expected sum of all DSH-eligible hospitals' Factor 3 values) by the actual sum of all DSH eligible hospitals' Factor 3 values and then multiply the quotient by the uncompensated care payment determined for each DSH eligible hospital to obtain a scaled uncompensated care payment amount for each hospital. This process is designed to ensure that the sum of the scaled uncompensated care payments for all hospitals that are projected to be DSH eligible is consistent with the estimate of the total amount available to make uncompensated care payments for the applicable fiscal year. In the proposed rule, we noted that a similar scaling factor methodology was previously used in both FY 2018 (82 FR 38214 and 38215) and FY 2019 (83 FR 41414), when the Factor 3 calculation also included multiple years of data.

We did not receive comments on this proposed scaling factor policy. We are finalizing as proposed.

• Modifications to New Hospital Policy for Purposes of Factor 3

We proposed to modify the new hospital policy that was initially adopted in the FY 2020 IPPS/LTCH PPS final rule to determine Factor 3 for new hospitals. Consistent with our proposal to use multiple years of cost reports to determine Factor 3, we proposed to define new hospitals as hospitals that do not have cost report data for the most recent year of data being used in the Factor 3 calculation. In other words, the cut-off date for the new hospital policy would be the beginning of the Federal fiscal year after the most recent year for which audits of the Worksheet S–10 data have been conducted. For FY 2023, the FY 2019 cost reports are the most recent year of cost reports for which audits of Worksheet S–10 data have been conducted. Thus, hospitals with CCNs established on or after October 1, 2019, would be subject to the new hospital policy in FY 2023.

Under the proposed modification to the new hospital policy, we would continue the policy established in the FY 2020 IPPS/LTCH PPS final rule (84 FR 42370) that 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 would not receive interim uncompensated care payments during FY 2023 because we would have no FY 2018 or FY 2019 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 2023 cost report.

We also proposed to modify the methodology used to calculate Factor 3 for new hospitals. Specifically, we proposed to determine Factor 3 for new hospitals using a denominator based solely on uncompensated care costs from cost reports for the most recent fiscal year for which audits have been conducted. For example, if a new hospital is ultimately determined to be eligible for Medicare DSH payments for FY 2023, 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 2023 cost report, and the denominator is the sum of the uncompensated care costs reported on Worksheet S–10 of the FY 2019 cost reports for all DSH-eligible hospitals. In addition, we proposed to apply a scaling factor, as discussed previously, to the Factor 3 calculation for a new hospital. We explained that we believe applying the scaling factor is appropriate for purposes of calculating Factor 3 for all hospitals, including new hospitals and hospitals that are treated as new hospitals, in order to improve consistency and predictability across all hospitals.

• Modifications to the Newly Merged Hospital Policy

In the FY 2023 IPPS/LTCH PPS rule, we stated that we will continue to treat hospitals that merge after the development of the final rule for the applicable fiscal year similar to new hospitals. As explained in the FY 2015 IPPS/LTCH PPS final rule, for these newly merged hospitals, we do not have data currently available to calculate a Factor 3 amount that accounts for the merged hospital's uncompensated care burden (79 FR 50021). In the FY 2015 IPPS/LTCH PPS final rule, we finalized a policy under which Factor 3 for hospitals that we do not identify as undergoing a merger until after the public comment period and additional review period following the publication of the final rule or that undergo a merger during the fiscal year 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 where 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 the proposed modification to the methodology used to determine Factor 3 for new hospitals described previously, we proposed to determine Factor 3 for newly merged hospitals using a denominator that is the sum of the uncompensated care costs for all DSH-eligible hospitals, as reported on Worksheet S–10 of their cost reports for the most recent fiscal year for which audits have been conducted. In addition, we would apply a scaling factor, as discussed previously, to the Factor 3 calculation for a newly merged hospital. We stated our belief that applying the scaling factor is appropriate for purposes of calculating Factor 3 for all hospitals, including new hospitals and hospitals that are treated as new hospitals, in order to improve consistency and predictability across all hospitals.

We also explained that 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, for FY 2023, the eligibility of a newly merged hospital to receive interim uncompensated care payments and the amount of any interim uncompensated care payments, would be based on the uncompensated care costs from the FY 2018 and FY 2019 cost reports available for the surviving

CCN at the time the final rule is developed. However, at cost report settlement, we would determine the newly merged hospital's final uncompensated care payment based on the uncompensated care costs reported on its FY 2023 cost report. That is, we would revise the numerator of Factor 3 for the newly merged hospital to reflect the uncompensated care costs reported on the newly merged hospital's FY 2023 cost report. The denominator would be the sum of the uncompensated care costs reported on Worksheet S–10 of the FY 2019 cost reports for all DSH-eligible hospitals, which is the most recent fiscal year for which audits have been conducted.

Comment: A couple of commenters expressed support for the policy currently in place for newly merged hospitals under which interim uncompensated care payments are based on the data for the surviving hospital's CCN available at the time of development of the final rule. These commenters also indicated support for continuing the policy in place for new hospitals, under which new hospitals with a CCN established on or after October 2019 with a preliminary projection of being eligible for DSH payments would receive interim empirically justified DSH payments. MACs would then make the final determination concerning whether a new hospital is eligible to receive DSH payments at cost report settlement based on the new hospital's FY 2023 cost report. One commenter requested that CMS provide clarification regarding which cost report would be used in the numerator of the Factor 3 calculation for a newly merged hospital or new hospital, and whether the cost report beginning or ending in FY 2023 would be used.

Response: We appreciate the support for our current policies for new and newly merged hospitals. In response to the comment asking for clarification on whether a newly merged hospital or new hospital would use its cost report beginning or ending in FY 2023, we note that the new hospital policy and the newly merged hospital policy are based on the start date of the hospital's cost reporting period. Specifically, the Factor 3 calculation for a new hospital will be based on the hospital's FY 2023 cost report (that is, a cost report with a start date on or after October 1, 2022, and on or before September 30, 2023). The numerator of the hospital's Factor 3 will be the hospital's total uncompensated care costs from the Worksheet S–10 Line 30 of its FY 2023 cost report (annualized, if necessary). The denominator will be the total national uncompensated care costs from the FY 2019 cost reports as calculated in this FY 2023 IPPS/LTCH PPS final rule. In the case of a new hospital or a newly merged hospital that has a cost report that spans multiple Federal fiscal years, if the cost report is a FY 2023 cost report, there is only one denominator in the Factor 3 calculation. In addition, the pro rata calculation (*i.e.,* the hospital's cost reporting period spans different Federal fiscal years) for a new hospital or a newly merged hospital is calculated using only the FY2023 total uncompensated care amount (that is, the Factor 3 is multiplied by the FY 2023 total uncompensated care amount, as finalized in this final rule.).

After consideration of the comments received, we are finalizing the proposed modifications to the new hospital and newly merged policies.

- 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 explained in the FY 2023 IPPS/LTCH PPS proposed rule (87 FR 28393) that we will apply the following steps to determine the applicable CCR for FY 2018 reports and FY 2019 reports separately:

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

Step 2: Calculate a CCR ''ceiling'' for the applicable fiscal year 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 the applicable fiscal year 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 the applicable fiscal year greater than 3 standard deviations above the national geometric mean for that fiscal year (that is, the CCR ''ceiling''). For purposes of both the proposed rule and this final rule, the statewide average CCR was applied to 8 hospitals' FY 2018 reports, of which 3 hospitals had FY 2018 Worksheet S–10 data. The statewide average CCR was applied to 14 hospitals' FY 2019 reports, of which 6 hospitals had FY 2019 Worksheet S–10 data.

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

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

We did not receive any comments on the discussion of CCR trim methodology. We are finalizing as proposed.

- Modifications to the Uncompensated Care Data Trim Methodology

After applying the CCR trim methodology, there are rare situations where a hospital has potentially aberrant uncompensated care data for a fiscal year that are unrelated to its CCR. Therefore, in the FY 2023 IPPS LTCH/PPS proposed rule, we explained that 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 IPPS/LTCH PPS final rule (85 FR 58832), if the hospital's uncompensated care costs for FY 2018 or FY 2019 are an extremely high ratio (greater than 50 percent) of its total operating costs in the applicable fiscal year, 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 for the applicable fiscal year. Specifically, if a hospital's FY 2018 cost report is determined to include potentially

aberrant data, data from its 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 2023. Because we proposed to use multiple years of cost reports in the Factor 3 calculation for FY 2023, we would apply this same approach to address potentially aberrant data in the FY 2019 cost report, by trimming based on the hospital's FY 2020 cost report.

In the FY 2023 IPPS/LTCH PPS proposed rule, we noted that we have audited the FY 2018 and the FY 2019 Worksheet S–10 data for a number of hospitals. Because the UCC data for these hospitals have been subject to audit, we stated our belief that 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, we stated that it would be unnecessary to apply the trim methodology for a fiscal year for which a hospital's UCC data have been audited.

In addition to the UCC trim methodology, we stated that we would continue to apply a trim specific to certain hospitals that do not have audited FY 2018 Worksheet S–10 data and/or audited FY 2019 Worksheet S–10 data. 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). Similar to the approach initially adopted in the FY 2022 IPPS/LTCH PPS final rule (86 FR 45245 and 45246), we proposed to continue to use a threshold of t3 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 that is the median total uncompensated care cost reported on most recent audited cost reports for hospitals that were projected to be DSH-eligible. We stated that we continue to believe these thresholds are appropriate, in order to address potentially aberrant data. However, we proposed to modify the calculation to include Worksheet S–10 data from IHS/Tribal hospitals and Puerto Rico hospitals consistent with our proposal to begin using Worksheet S–10 data to determine Factor 3 for these hospitals. We also proposed to apply the same thresholds to identify potentially aberrant charity care costs data for all cost reporting years that are used in determining Factor 3. We noted that based on calculations from the FY 2019 reports, the threshold amounts were similar to FY 2018 reports; therefore, we explained that we believe it is reasonable to use the same thresholds to identify aberrant data for both years. Thus, under the proposal, in FY 2023 we would use the same thresholds to identify potentially aberrant data for both FY 2018 and FY 2019 reports. In addition, we proposed to apply the same threshold amounts originally calculated for the FY 2018 reports to identify potentially aberrant data for subsequent fiscal years in order to facilitate transparency and predictability. Therefore, for FY 2023 and subsequent fiscal years, 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, we would exclude the hospital from the prospective Factor 3 calculation. We explained that this 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. Consistent with the approach adopted in the FY 2022 IPPS/LTCH PPS final rule, if a hospital would be trimmed under both the UCC trim methodology and this alternative trim, we would apply this trim in place of the existing UCC trim methodology. We stated that we continue to believe this alternative trim more appropriately addresses potentially aberrant insured patient charity care costs compared to the UCC trim methodology, because the UCC 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 proposed to continue to apply the policy adopted in the FY 2022 IPPS/LTCH PPS final rule, for the hospitals that would be subject to this alternative trim and are ultimately determined to be DSH-eligible at cost report settlement. We explained that if a hospital subject to this 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 2023 Worksheet S–10 has been reviewed. Accordingly, the MAC would calculate a Factor 3 for the hospital only after reviewing the uncompensated care information reported on Worksheet S–10 of the hospital's FY 2023 cost report. Then we would calculate Factor 3 for a hospital subject to this alternative trim using the same methodology used to determine Factor 3 for new hospitals. Specifically, the numerator would reflect the uncompensated care costs reported on the hospital's FY 2023 cost report, while the denominator would reflect the sum of the uncompensated care costs reported on Worksheet S–10 of the FY 2019 cost reports of all DSH-eligible hospitals. In addition, consistent with our proposed approach for new hospitals, we would apply a scaling factor, as discussed previously, to the Factor 3 calculation for these hospitals. We stated that we believe applying the scaling factor is appropriate for purposes of calculating Factor 3 for all hospitals, including new hospitals and hospitals that are treated as new hospitals, in order to improve consistency and predictability across all hospitals.

We did not receive any comments on the proposed modifications to the uncompensated care data trim methodology. We are finalizing as proposed.

- Summary of Methodology

In summary, under the policies we are finalizing in this FY 2023 IPPS/LTCH PPS final rule, for FY 2023, we will compute Factor 3 for each hospital using the following steps:

Step 1: Select the hospital's longest cost report from its Federal fiscal year (FY) 2018 cost reports and the longest cost report from its FY 2019 cost reports. (Alternatively, in the rare case when the hospital has no cost report for a particular year because the cost report for the previous Federal fiscal year spanned the more recent Federal fiscal year, the previous Federal fiscal year cost report will be used in this step. In the rare case, that using a previous Federal fiscal year cost report results in a period without a report, we will use the prior year report, if that cost report spanned the applicable period. (For example, if a hospital does not have a FY 2019 cost report because the hospital's FY 2018 cost report spanned the FY 2019 time period, then we will use the FY 2018 cost report that spanned the FY 2019 time period for this step. Using the same example, where the hospital's FY 2018 report is

used for the FY 2019 time period, then we will use the hospital's FY 2017 report if it spans some of the FY 2018 time period. In other words, we will not use the same cost report for both the FY 2019 and the FY 2018 time periods.) In general, we note that, for purposes of the Factor 3 methodology, references to a fiscal year cost report are to the cost report that spans the relevant Federal fiscal year period.

Step 2: Annualize the uncompensated care costs (UCC) from Worksheet S–10 Line 30, if a 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 all DSH eligible hospitals using annualized uncompensated care costs (Worksheet S–10 Line 30) based on FY 2018 cost report data and FY 2019 cost report data (from Step 1, 2 or 3). New hospitals and other hospitals that are treated as if they are new hospitals for purposes of Factor 3 are excluded from this calculation.

Step 5: Average the Factor 3 values from Step 4; that is, add the Factor 3 values for FY 2018 and FY 2019 for each hospital, and divide that amount by the number of cost reporting periods with data to compute an average Factor 3 for the hospital. Multiply by a scaling factor.

For FY 2024 and subsequent fiscal years, these steps will be calculated using the most recent 3 years of audited cost reports. (For example, in FY 2024, the FY 2018, FY 2019, and FY 2020 reports would be used.)

In the FY 2023 IPPS/LTCH PPS proposed rule, we proposed to make a conforming change to the existing regulation at § 412.106(g)(1)(iii)(C)(*8*) and to add a new regulation at § 412.106(g)(1)(iii)(C)(*10*) to reflect our proposal to calculate Factor 3 based on the most recent two years of audited data on uncompensated care costs in FY 2023. We also proposed to add § 412.106(g)(1)(iii)(C)(*11*) to reflect our proposal to calculate Factor 3 for FY 2024 and subsequent fiscal years based on a 3-year average of the most recent available audited data on uncompensated care costs.

We did not receive any comments on these proposed changes to regulations. We are finalizing the proposed changes with only minor conforming changes for internal consistency.

(d) 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.

In the FY 2022 IPPS/LTCH PPS final rule (86 FR 45247 and 45248), we modified this calculation for FY 2022 to be based on an average of FY 2018 and FY 2019 historical discharge data, rather than a 3-year average that included 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 COVID–19 pandemic. For the same reason, we proposed to modify this calculation for FY 2023 to be based on the average of FY 2018, FY 2019, and FY 2021 historical discharge data, rather than a 3-year average of the most recent 3 years of discharge data from FY 2019, FY 2020, and FY 2021. We stated that computing a 3-year average using the most recent 3 years would potentially underestimate the number of discharges for FY 2023, due to the effects of the COVID–19 pandemic in FY 2020, which was the first year of the COVID–19 pandemic. Therefore, we explained our belief that the proposed modification may result in a better estimate of the number of discharges during FY 2023, for purposes of the interim uncompensated care payment calculation. In addition, we noted that our proposal to include discharge data from FY 2021 to compute this 3-year average was consistent with the proposed use of FY 2021 Medicare claims in the IPPS ratesetting, as discussed in section I.F. of the preamble of the FY 2023 IPPS/LTCH PPS proposed rule. Under this proposal, the resulting 3-year average of the number of discharges would be used to calculate a per discharge payment amount that will be used to make interim uncompensated care payments to each projected DSH-eligible hospital during FY 2023. We also explained that the interim uncompensated care payments made to a hospital during the fiscal year will be 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 FY 2023.

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 that 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 the hospital's projected FY 2023 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 this final

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: 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 federal fiscal year. These same commenters also asserted that CMS has failed to provide a meaningful opportunity to review and comment on the more recent data used in developing the final rule before the agency publishes the final rule.

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; 84 FR 42373; 85 FR 58833 and 86 FR 45246). 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 commenters' suggestion that we should establish a process for reconciling our estimates of uncompensated care payments, which would be contrary to the notion of a prospective payment system. 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 2023 IPPS/LTCH PPS proposed rule included a detailed discussion of our proposed methodology for calculating Factor 3 and the data that would be used. We made public the best data available at the time of the proposed rule in order to allow hospitals to understand the anticipated impact of the proposed methodology and submit comments, and we have considered those comments in determining our final policies for FY 2023.

(e) 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 2023 (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 an uncompensated care 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 new hospitals and hospitals that are subject to the alternative trim for hospitals with potentially aberrant data that are not projected to be DSH-eligible.

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 10 hospitals that would be subject to the alternative trim for hospitals with potentially aberrant data that are not projected to be DSH-eligible, with a N/A in the Factor 3 column.

Hospitals had 60 days from the date of public display of the FY 2023 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 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 or concerns that are specific to the information included in the table and supplemental data file could be submitted by email 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 this FY 2023 IPPS/LTCH PPS final rule. All other comments submitted in response to our proposed policies for determining uncompensated care payments for FY 2023 must have been submitted in one of the 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, we note that the CMS DSH inbox is not intended for Worksheet S–10 audit process related emails, which should be directed to the MACs.

For FY 2023, we again proposed that hospitals would have 15 business days from the date of public display of this FY 2023 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. Any changes to Factor 3 would be posted on the CMS website and would be effective beginning October 1, 2022. 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 the proposed rule, we expected to use data from the March 2022 HCRIS extract for the FY 2023 final rule, which contributed to our increased confidence that hospitals would have be able to comment on mergers and report any upload discrepancies during the comment period for the FY 2023 IPPS/LTCH PPS proposed rule. However, we noted that in the event that there were 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 2023 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.

We did not receive comments on the notification process for mergers or data upload issues. We are finalizing our proposal to afford hospitals 15 business days from the public display of this FY 2023 IPPS/LTCH PPS final rule to submit via email any updated information on mergers and/or to report upload discrepancies. We also note that the historical FY 2018 and FY 2019 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.

E. Supplemental Payment for Indian Health Service and Tribal Hospitals and Puerto Rico Hospitals for FY 2023 and Subsequent Fiscal Years

In the IPPS/LTCH PPS rulemaking for several previous fiscal years, Indian Health Service (IHS) and Tribal hospitals and hospitals located in Puerto Rico have commented about the unique challenges they face with respect to uncompensated care due to structural differences in health care delivery and financing in these areas compared to the rest of the country. In the FY 2023 IPPS/LTCH PPS proposed rule (87 FR 28396), we referred readers to the FY 2022 IPPS/LTCH PPS final rule (86 FR 45242 and 45243) and the FY 2021 IPPS/LTCH PPS final rule (85 FR 58824 and 58825) for a discussion of these comments. We also explained that we appreciated the concerns raised and the input offered by commenters regarding the methodology for calculating uncompensated care payments for IHS/Tribal hospitals and the Puerto Rico hospitals. After taking into consideration stakeholders' longstanding concerns and their input on potential approaches to address these concerns, we proposed to establish a new permanent supplemental payment under the IPPS for IHS/Tribal hospitals and hospitals located in Puerto Rico. As discussed in greater detail in the proposed rule, we stated our belief that the proposed new supplemental payment would mitigate the anticipated impact on IHS/Tribal hospitals and hospitals located in Puerto Rico from our proposal to discontinue the use of low-income insured days as a proxy for their uncompensated care costs for purposes of determining Factor 3 of the uncompensated care payment methodology by providing for an additional payment to these hospitals that would be determined based upon the difference between the amount of the uncompensated care payment determined for the hospital using Worksheet S–10 data and an approximation of the amount the hospital would have received if we had continued to use low-income insured days as a proxy for uncompensated care.

As background, beginning in the FY 2018 IPPS/LTCH PPS final rule when we first included Worksheet S–10 data in the calculation of Factor 3, and continuing through the FY 2022 IPPS/LTCH PPS final rule, we relied on the authority under section 1886(r)(2)(C)(i) of the Act to use alternative data that is a better proxy for the costs of hospitals for treating the uninsured in order to determine Factor 3 for IHS/Tribal and Puerto Rico hospitals using low-income insured days as a proxy for uncompensated care costs. Since FY 2019, Factor 3 for these hospitals has been determined using FY 2013 Medicaid days and the most recent available data on SSI days. We believed this approach was appropriate as the FY 2013 Medicaid days 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 low-income insured 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 initially adopted in the FY 2017 IPPS/LTCH PPS final rule (81 FR 56953 through 56956). However, we recognized that our proposal, which we are finalizing in this final rule, to discontinue the use of low-income insured days as a proxy for uncompensated care costs would result in a significant financial disruption to the IHS/Tribal hospitals and hospitals located in Puerto Rico. We explained that, for the vast majority of these hospitals, the proposal to use uncompensated care data reported on Worksheet S–10 to determine Factor 3 of the uncompensated care payment methodology would be expected to result in an approximately 90 to 100 percent reduction in uncompensated care payments for FY 2023 compared to FY 2022. We referred readers to section I.H. of Appendix A of the proposed rule for a discussion of the anticipated impact of the proposal to use uncompensated care costs from Worksheet S–10 to determine uncompensated care payments for IHS/Tribal hospitals and Puerto Rico hospitals and the proposal to establish a new supplemental payment for these hospitals.

In consideration of the unique circumstances faced by the hospitals and the comments received from IHS/Tribal hospitals and Puerto Rico hospitals in response to prior rulemaking, raising concerns regarding financial stability in the event of a change in the data used to determine Factor 3, we proposed to use our exceptions and adjustments authority under section 1886(d)(5)(I) of the Act to establish a new permanent supplemental payment under the IPPS for IHS/Tribal hospitals and hospitals located in Puerto Rico, beginning in FY 2023. Section 1886(d)(5)(I) of the Act authorizes the Secretary to provide by regulation for such other exceptions and adjustments to the payment amounts under section 1886(d) of the Act as the Secretary deems appropriate. We have determined, after taking into consideration stakeholders' comments from prior rulemakings, that the supplemental payment is necessary so as not to cause undue long-term financial disruption to these hospitals as a result of our proposal to discontinue the use of low-income insured days as a proxy for uncompensated care in determining Factor 3 for IHS/Tribal hospitals and Puerto Rico hospitals beginning in FY 2023. In the proposed rule, we stated our belief that the proposed supplemental payment would help to mitigate the anticipated impact of the proposed changes to the uncompensated care payment methodology for these hospitals and therefore prevent undue long-term financial disruption for these providers.

We also stated that the proposed new supplemental payment would not change in any way the DSH payment methodology under section 1886(d)(5)(F) of the Act or the uncompensated care payment methodology under section 1886(r) of the Act. Therefore, the total uncompensated care payment amount would not be affected by this proposal to establish a supplemental payment for IHS/Tribal and hospitals located in Puerto Rico nor would there be any impact on the amount of the uncompensated care payment determined for each DSH-eligible hospital under § 412.106(g)(1) of the regulations.

We proposed that for IHS and Tribal hospitals and hospitals located in Puerto Rico for which Factor 3 of the uncompensated care payment methodology was determined using the low-income insured days proxy in FY

2022, we would calculate a supplemental payment as follows. We would use the hospital's FY 2022 uncompensated care payment as the starting point for this calculation. We explained that using the FY 2022 uncompensated care payment would be an appropriate starting point because FY 2022 is the most recent year for which we used low-income insured days data in the determination of uncompensated care payments for IHS/Tribal hospitals and Puerto Rico hospitals and the purpose of the proposed supplemental payment is to avoid undue long-term financial disruption to these hospitals as a result of our proposal to discontinue the use of low-income insured days as a proxy for uncompensated care beginning in FY 2023. The base year amount would be calculated as the hospital's FY 2022 uncompensated care payment adjusted by one plus the percent change in the total uncompensated care amount between the applicable year (for example, FY 2023 for purposes of this rulemaking) and FY 2022, where the total uncompensated care amount for a year is determined as the product of Factor 1 and Factor 2 for the applicable year. For example, if a hospital's FY 2022 uncompensated care payment was 1 million, and the percent change between FY 2023 and FY 2022 total uncompensated care payments was negative 9.1 percent, then the hospital's FY 2023 base year amount would be 1 million * (1+(−0.091)), which is 909,000. For the hospitals that were not projected to be DSH eligible in FY 2022, we proposed to use the uncompensated care payment that the hospital would receive, if the hospital were to be determined to be DSH eligible in FY 2022 at cost report settlement. For purposes of the proposed rule, the percent change between the proposed FY 2023 uncompensated care amount and final FY 2022 uncompensated care amount was projected to be negative 9.1 percent. (This negative 9.1 percent change was calculated based on the difference between the proposed FY 2023 uncompensated care amount of approximately $6.537 billion and the final FY 2022 uncompensated care amount of approximately $7.192 billion, divided by the final FY 2022 uncompensated care amount). Therefore, we proposed to calculate each hospital's base year amount for FY 2023 by multiplying its FY 2022 uncompensated care amount by 0.909 (1–0.091). We note that in order to determine the base year amount for a future fiscal year, the calculation would be the hospital's FY2022 uncompensated care amount multiplied by one plus the percent change in total uncompensated care payments between FY 2022 and the applicable fiscal year. The hospital's supplemental payment for a fiscal year would then be determined as the difference between the hospital's base year amount and its uncompensated care payment for the applicable fiscal year as determined under § 412.106(g). If the base year amount is equal to or lower than the hospital's uncompensated care payment for the current fiscal year, the hospital would not receive a supplemental payment because the hospital would not be experiencing financial disruption in that year as a result of the use of uncompensated care data from the Worksheet S–10 in determining Factor 3 of the uncompensated care payment methodology.

We proposed to align the eligibility and payment processes for the new supplemental payment with the processes used to make uncompensated care payments. Consistent with the process for determining eligibility to receive interim uncompensated care payments adopted in the FY 2014 IPPS/LTCH final rule, for the supplemental payment, we proposed to base eligibility to receive interim supplemental payments on a projection of DSH eligibility for the applicable fiscal year. In addition, consistent with the approach that is used to calculate interim uncompensated care payments on a per discharge basis, for the supplemental payment, we proposed to use an average of historical discharges to calculate a per discharge amount for interim supplemental payments. We referred readers to the FY 2014 IPPS/LTCH PPS final rule for additional background and discussion of uncompensated care payment processes (78 FR 50643 through 50647). Consistent with our proposal to use 3 years of historical discharges to determine interim uncompensated care payments for a fiscal year, we proposed that the amount of a hospital's supplemental payment calculated for a fiscal year would be divided by the hospital's historical 3-year average of discharges computed using the most recent available data to determine an estimated per discharge payment amount.

For FY 2023, we proposed to use FY 2018, FY 2019, and FY 2021 discharge data to determine a hospital's historical 3-year average of discharges, because we continued to believe the FY 2020 discharge data would underestimate discharges, due to the effects of the COVID–19 pandemic in FY 2020. In addition, consistent with the policy of including per-discharge uncompensated care payment amounts in the outlier calculation, which was initially adopted in the FY 2014 IPPS/LTCH PPS final rule, we proposed to use our authority under section 1886(d)(5)(I) of the Act to include the per-discharge supplemental payment in the outlier payment determination under section 1886(d)(5)(A) of the Act. We referred readers to the Addendum to the proposed rule for further discussion of the outlier payment calculation.

Consistent with the process used to reconcile interim uncompensated care payments, we proposed that the MAC would reconcile the interim supplemental payments at cost report settlement to ensure that the hospital receives the full amount of the supplemental payment that was determined prior to the start of the fiscal year. Consistent with the process used for cost reporting periods that span multiple Federal fiscal years, we proposed that a pro rata supplemental payment calculation may be made if the hospital's cost reporting period differs from the Federal fiscal year. Thus, the final supplemental payment amounts that would be included on a cost report spanning two Federal fiscal years would be the pro rata share of the supplemental payment associated with each Federal fiscal year. This pro rata share would be determined based on the proportion of the applicable Federal fiscal year that is included in that cost reporting period. We referred readers to the FY 2014 interim final rule for additional background and discussion of the processes for determining pro rata uncompensated care payments (78 FR 61191 through 61196).

We proposed that the MAC would make a final determination with respect to a hospital's eligibility to receive the supplemental payment for a fiscal year, in conjunction with its final determination of the hospital's eligibility for DSH payments and uncompensated care payments for that fiscal year. We noted that if a hospital is determined not to be DSH eligible for a fiscal year then the hospital would not be eligible to receive a supplemental payment for that fiscal year. In the proposed rule, we stated our belief that linking eligibility for the supplemental payment to eligibility for DSH payments and the uncompensated care payment is appropriate because a hospital that is not eligible to receive an uncompensated care payment for a fiscal year would not experience any financial disruption due to the discontinuation of the low-income insured days proxy and the use of

Worksheet S–10 data in determining Factor 3 for that fiscal year.

In addition, we proposed that IHS/Tribal hospitals and Puerto Rico hospitals that do not have a FY 2022 Factor 3 amount determined under § 412.106(g)(1)(iii)(C)(9) using the low-income insured days proxy or that are new hospitals that begin participating in the Medicare program on or after October 1, 2022, would not be eligible to receive the supplemental payment. We explained that these hospitals will not experience any reduction to their uncompensated care payments due to the proposed discontinuation of the low-income insured days proxy because they are not currently receiving uncompensated care payments determined using the proxy. We proposed to redesignate the existing provision at § 412.106(h) as § 412.106(i) and to add a new provision at § 412.106(h) to reflect the methodology for calculating the supplemental payment for FY 2023 and subsequent fiscal years.

We sought comments on our proposal to establish this new supplemental payment for IHS/Tribal hospitals and Puerto Rico hospitals. As discussed in section IV.D.3. of this final rule, we also solicited comments on alternatives both to our proposal to use data on uncompensated care costs from the Worksheet S–10 to determine Factor 3 for IHS/Tribal hospitals and Puerto Rico hospitals and to the continued use of low-income insured days as a proxy for the uncompensated care costs of these hospitals. In addition, we sought comments on how to best measure and define the uncompensated care costs associated with these hospitals that might not otherwise be captured in Factor 3 calculations based on Worksheet S–10 data. Given the close interrelationship between our proposed changes to the methodology for determining Factor 3 of the uncompensated care payment methodology for IHS/Tribal hospitals and Puerto Rico hospitals and the proposed new supplemental payment for these hospitals, we discuss the comments received on both proposals in this section of this final rule.

Comment: The majority of commenters expressed appreciation for CMS' creativity in devising the proposed new supplemental payment to mitigate the anticipated financial impact from the discontinuation of low-income insured days as a proxy for uncompensated care costs for IHS and Tribal hospitals and hospitals located in Puerto Rico. Some commenters stated there are longstanding inequities in DSH and uncompensated care calculations for Puerto Rico hospitals due to the lack of an SSI benefit for residents of the U.S. territories. These commenters also suggested an alternative methodology for calculating the supplemental payment for hospitals in Puerto Rico.

Specifically, the commenters recommended that CMS calculate the supplemental payment for Puerto Rico hospitals using a base year amount determined from Medicaid days and an SSI days proxy of at least 40 percent but no less than 35 percent of Medicaid days, instead of the current 14 percent. Commenters further suggested that CMS determine a second empirical DSH eligibility threshold for hospitals in Puerto Rico based on the suggested SSI days proxy of 40 percent of Medicaid days, such that if the sum of the Medicaid fraction and the SSI days proxy exceeds 15 percent, then the hospital would be eligible to receive uncompensated care payments and the new supplemental payment. A commenter, in support of this alternative methodology, noted that, under the proposed supplemental payment methodology, Puerto Rico hospitals would receive an 11.06 percent reduction in Medicare DSH payments in FY 2023 as compared to FY 2022. The same commenter noted that the reduction in DSH payments could also reduce Medicare Advantage (MA) benchmarks for Puerto Rico in 2024 and, as a result, impact approximately 630,000 Medicare beneficiaries enrolled in MA plans, including 280,000 dual-eligible individuals.

Another commenter expressed support for the proposed discontinuation of low-income insured days as a proxy for uncompensated care costs for IHS and Tribal hospitals and hospitals located in Puerto Rico. However, this commenter recommended that CMS reduce the size of supplemental payments to hospitals in Puerto Rico to an empirically justified level. This commenter noted that the continued use of Medicaid days as a proxy for uncompensated care costs in Puerto Rico has resulted in a substantial increase in uncompensated care payments. Further, this commenter stated that maintaining the overall payments at the proposed levels through the supplemental payment would create high Medicare profit margins at Puerto Rico hospitals and distort the MA benchmarks, as it would increase FFS spending by more than 25 percent above what it would have been if Puerto Rico hospitals received uncompensated care payments based only on their reported uncompensated care costs. The commenter also opposed the disbursement of the supplemental payments as an add-on payment to the IPPS payment rates for hospitals in Puerto Rico and recommended that uncompensated care payments not be factored into MA benchmarks.

A few commenters expressed support for the proposed supplemental payment without suggesting enhancements to the policy. One of these commenters emphasized the importance of implementing the supplemental payment as a permanent policy.

A commenter opposed CMS' proposal to discontinue the calculation of uncompensated care costs using low income insured days for hospitals in Puerto Rico without a separate policy in place for receiving the supplemental payment. Instead, the commenter suggested that CMS use a phased approach such that the agency would continue to calculate uncompensated care costs for hospitals in Puerto Rico using low income insured days until a future rulemaking. The commenter further suggested that CMS eventually phase in payments calculated using Worksheet S–10 along with the supplemental payment.

Another commenter specifically opposed the exclusion of new hospitals in Puerto Rico from receiving the supplemental payment. The same commenter noted that because hospitals newly established after October 2013 did not have Medicaid days for the period before the Affordable Care Act was implemented, the uncompensated care costs for these hospitals are already calculated using Worksheet S–10 but with no supplemental payments. The commenter also noted that because hospitals established after October 2013 operate under the same conditions as hospitals established before October 2013, these hospitals should receive the proposed supplemental payments in a manner similar to those hospitals for which we proposed to transition to the use of Worksheet S–10 data to determine uncompensated care costs starting in FY 2023. Finally, this commenter requested that CMS consider calculating uncompensated care costs for an impacted Puerto Rico hospital (established after 2013) for the period from FY 2020 through FY 2022 using Medicaid days and not Worksheet S–10 data.

Response: We appreciate this input from commenters regarding the proposal to establish a new supplement payment for hospitals in Puerto Rico and IHS and Tribal hospitals and the concerns raised regarding the proposed changes to the data used to determine uncompensated care costs for these hospitals. We continue to recognize the unique financial circumstances and challenges

faced by Puerto Rico hospitals related to uncompensated care cost reporting on Worksheet S–10. With regard to the recommendation to calculate the supplemental payment using a base year amount determined using Medicaid days and an SSI days proxy of at least 40 percent, we note that since FY 2019, Factor 3 for hospitals in Puerto Rico has been determined using FY 2013 Medicaid days and the most recent available data on SSI days and because 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 initially adopted in the FY 2017 IPPS/LTCH PPS final rule (81 FR 56953 through 56956). We also note that we did not receive comments expressing concerns regarding this policy when it was finalized for FY 2019. However, for the reasons explained in the FY 2023 IPPS/LTCH PPS proposed rule (87 FR 28391), we have determined that data on low income insured days is no longer a good proxy for the costs of hospitals in treating the uninsured and that we can no longer conclude that alternative data to the data on uncompensated care costs reported on the Worksheet S–10 are available for Puerto Rico hospitals that are a better proxy for the costs of these hospitals in treating the uninsured.

With respect to the comment recommending that we adopt a second eligibility threshold for empirically justified DSH payments based on the suggested SSI days proxy of 40 percent of Medicaid days, we note that in the FY 2023 IPPS/LTCH PPS proposed rule, we did not propose to adopt a proxy for Puerto Rico hospitals' SSI days for purposes of determining eligibility to receive DSH payments and calculating the empirically justified Medicare DSH payment. Therefore, we consider this comment to be outside the scope of the proposed rule. We note, however, that while section 1886(r)(2)(C)(i) of the Act allows for the use of alternative data as a proxy to determine the costs of subsection (d) hospitals for treating the uninsured for purposes of determining uncompensated care payments, section 1886(r)(1) of the Act requires the Secretary to pay an empirically justified DSH payment that is equal to 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. Section 1886(d)(5)(F)(vi) of the Act, which prescribes the disproportionate patient percentage used to determine empirically justified Medicare DSH payments, specifically refers to the SSI days in the Medicare fraction and does not allow the use of alternative data. Accordingly, we disagree with the commenter's assertion that there is legal support for CMS to use a proxy for Puerto Rico hospitals' SSI days in the calculation of the empirically justified Medicare DSH payment.

Regarding the comment that hospitals in Puerto Rico hospitals will receive an 11.06 percent reduction in Medicare DSH payments in FY 2023 as compared to FY 2022, we note that, under the policies we are finalizing in this final rule, the combined amount of uncompensated care payments and supplemental payments for FY 2023 will be less than 11.06 percent below the amount of uncompensated care payments for FY 2022. We refer readers to the discussion of the impact of our final policies regarding Medicare uncompensated care payments and the new supplemental payment in Section I.H. of Appendix A of this final rule. In addition, we note that the base year amount used in calculating the supplemental payment will change over time relative to the total uncompensated care amount. Accordingly, for years in which there is an increase in the total uncompensated care total amount, the hospital's supplemental payment calculation would reflect a higher base year amount, and for the years in which there is a decrease in the total uncompensated care total amount, the hospital's supplemental payment calculation would reflect a lower base year amount.

With regard to the comment that the supplemental payment would impact the Medicare Advantage benchmarks, we believe the combined amount of empirically justified DSH payments, uncompensated care payments, and supplemental payments to IHS/Tribal hospitals and Puerto Rico hospitals will be comparable to the amount these hospitals would have received if CMS had continued to use the low-income days proxy to determine Factor 3 of the uncompensated care payment methodology. As a result, the new supplemental payments are expected to have no impact on MA benchmarks in Puerto Rico. Given that the MA capitation calculations are on a different timeline than the annual rulemaking for the IPPS (that is, calendar year rather than Federal fiscal year), the 2024 MA benchmarks would be the first time any effects would be reflected.

We disagree with the commenter who noted that there is no mechanism in place for receiving the supplemental payment. We refer readers to the FY 2014 IPPS/LTCH PPS proposed rule for additional background and discussion of uncompensated care payment processes (78 FR 50643 through 50647). As discussed in the FY 2023 IPPS/LTCH PPS proposed rule, we proposed to determine an estimated per discharge add-on payment amount based on the amount of a hospital's supplemental payment calculated for a fiscal year divided by the hospital's historical three-year average of discharges, computed using the most recently available data.

Regarding the concerns raised with respect to our proposal that hospitals in Puerto Rico established after October 2013 would be ineligible to receive the supplemental payment, we note that, as explained in the FY 2023 IPPS/LTCH PPS proposed rule, we proposed to establish the supplemental payment to mitigate any long-term financial disruption as a result of our proposal to discontinue the use of low-income insured days as a proxy for uncompensated care costs in determining Factor 3. Uncompensated care costs for Puerto Rico hospitals established after October 2013 are already determined using Worksheet S–10 data. As a result, these hospitals will not experience any reduction to their uncompensated care payments due to the proposed discontinuation of the low-income insured days proxy because they are not currently receiving uncompensated care payments determined using the proxy. Thus, we do not believe it is appropriate to modify the proposed eligibility criteria for the supplemental payment to include these hospitals at this time. However, we intend to monitor uncompensated care payments to these hospitals and may revisit this issue in future rulemaking.

Regarding the commenter that requested that CMS consider calculating the uncompensated care costs for FY 2020 through FY 2022 for a Puerto Rico hospital (established after 2013) using Medicaid days and not Worksheet S–10 data, we believe this comment is out of scope of this rulemaking. We note that the policy for new hospitals in Puerto Rico was initially adopted in the FY 2019 IPPS/LTCH PPS final rule, and we did not propose any modifications to this policy in the FY 2023 IPPS/LTCH PPS proposed rule.

Comment: Commenters expressed support for CMS' proposal to establish a new supplemental payment for IHS and Tribal hospitals to mitigate the anticipated impact of the agency's proposal to discontinue the use of low-income insured days as a proxy to calculate uncompensated care payments for these hospitals. Commenters requested that CMS confirm that the

supplemental payments would result in an equal or higher uncompensated care payment amount than in prior years. Commenters also opposed the exclusion of new IHS and Tribal hospitals from receiving the supplemental payment, with another commenter suggesting that CMS finalize the supplemental payment for existing IHS/Tribal hospitals as an interim measure while the agency devises an alternate approach that would be applicable to all IHS/Tribal hospitals. These commenters also urged CMS to provide an option for hospitals to opt out of the new supplemental payment methodology in the future years if they preferred payment in a manner similar to non-Tribal hospitals.

Response: We appreciate the input from commenters on our proposal to establish a new supplemental payment for IHS and Tribal hospitals. We continue to recognize the unique nature of these hospitals and the special circumstances they face.

Regarding commenters' request that CMS confirm that the proposed supplemental payment will result in an overall payment amount that is equal to or higher than the uncompensated care payments for prior years determined using the low-income days proxy, we note that the base year amount used to calculate a hospital's supplemental payment will change over time relative to changes in the total uncompensated care amount. For years in which there is an increase in the total uncompensated care total amount, the hospital's supplemental payment calculation would use a higher base year amount, and for the years in which there is a decrease in the total uncompensated care total amount, the hospital's supplemental payment calculation would use a lower base year amount.

Regarding the concerns raised by commenters with respect to our proposal to limit the new supplemental payment to existing IHS/Tribal hospitals that have a Factor 3 amount for FY 2022 determined using the low-income insured days proxy, we note that, as explained in the FY 2023 IPPS/LTCH PPS proposed rule, we proposed to establish the supplemental payment to mitigate any long-term financial disruption as a result of our proposal to discontinue the use of low-income insured days as a proxy for uncompensated care costs in determining Factor 3. However, new IHS/Tribal hospitals for which uncompensated care costs have not previously been determined using the low-income insured days proxy will not experience any reduction to their uncompensated care payments due to the proposed discontinuation of the proxy. Thus, we do not believe it is appropriate to extend the supplemental payment to include new IHS/Tribal hospitals at this time. However, we will monitor uncompensated care payments to these hospitals and may revisit this issue in future rulemaking.

In regard to an option for hospitals to opt out of the new supplemental payment methodology in the future years, we believe that no modification to our proposed methodology is necessary, because, under the proposed supplemental payment methodology, which we are finalizing in this final rule, an IHS/Tribal hospital or Puerto Rico hospital will receive the full uncompensated care payment determined using its Worksheet S–10 data. A hospital will only receive the supplemental payment if it increases the overall amount payable to the hospital, so there does not appear to be a clear reason for a hospital to opt out of the supplemental payment.

After consideration of the comments received, we are finalizing both our proposal to discontinue the use of the low-income insured days proxy and to rely solely on Worksheet S–10 data to calculate Factor 3 of the uncompensated care payment methodology for IHS/Tribal hospitals and Puerto Rico hospitals and our proposal to establish a new supplemental payment for Puerto Rico hospitals and IHS/Tribal hospitals, without modification. We are also finalizing the proposed provision at § 412.106(h) governing the new supplemental payment without modification.

The percent change between the final FY 2023 uncompensated care amount and final FY 2022 uncompensated care amount is negative 4.4 percent. (This negative 4.4 percent change is calculated based on the difference between the final FY 2023 uncompensated care amount of approximately $6.874 billion and the final FY 2022 uncompensated care amount of approximately $7.192 billion, divided by the final FY 2022 uncompensated care amount). Therefore, consistent with the methodology in § 412.106(h)(3)(i), we will calculate each hospital's base year amount for FY 2023 by multiplying its FY 2022 uncompensated care amount by 0.956 (1 − 0.044).

F. Medicare Disproportionate Share Hospital (DSH) Payments: Counting Days Associated With Section 1115 Demonstrations in the Medicaid Fraction (§ 412.106)

In the FY 2023 IPPS/LTCH PPS proposed rule, we proposed revisions to the regulation relating to the treatment of section 1115 demonstration days for purposes of the DSH adjustment (87 FR 28398 through 28402). The agency received numerous, detailed comments on this proposal. We thank the commenters for their input on the proposal. Due to the number and nature of the comments that we received on our proposal, and after further consideration of the issue, we have determined not to move forward with the current proposal. We expect to revisit the treatment of section 1115 demonstration days for purposes of the DSH adjustment in future rulemaking, and we encourage interested parties to review any future proposal on this issue and to submit their comments at that time.

V. Other Decisions and Changes to the IPPS for Operating Costs

A. Changes in the Inpatient Hospital Update for FY 2023 (§ 412.64(d))

1. FY 2023 Inpatient Hospital Update

In accordance with section 1886(b)(3)(B)(i) of the Act, each year we update the national standardized amount for inpatient hospital operating costs by a factor called the ''applicable percentage increase.'' For FY 2023, we stated in the proposed rule that we are setting the applicable percentage increase by applying the adjustments listed in this section in the same sequence as we did for FY 2022. (We note that section 1886(b)(3)(B)(xii) of the Act required an additional reduction each year only for FYs 2010 through 2019.) Specifically, consistent with section 1886(b)(3)(B) of the Act, as amended by sections 3401(a) and 10319(a) of the Affordable Care Act, we stated that we are setting the applicable percentage increase by applying the following adjustments in the following sequence. The applicable percentage increase under the IPPS for FY 2023 is equal to the rate-of-increase in the hospital market basket for IPPS hospitals in all areas, subject to all of the following:

- A reduction of one-quarter of the applicable percentage increase (prior to the application of other statutory adjustments; also referred to as the market basket update or rate-of-increase (with no adjustments)) for hospitals that fail to submit quality information under rules established by the Secretary in accordance with section 1886(b)(3)(B)(viii) of the Act.
- A reduction of three-quarters of the applicable percentage increase (prior to the application of other statutory adjustments; also referred to as the market basket update or rate-of-increase

(with no adjustments)) for hospitals not considered to be meaningful EHR users in accordance with section 1886(b)(3)(B)(ix) of the Act.

• An adjustment based on changes in economy-wide multifactor productivity (MFP) (the productivity adjustment).

Section 1886(b)(3)(B)(xi) of the Act, as added by section 3401(a) of the Affordable Care Act, states that application of the productivity adjustment may result in the applicable percentage increase being less than zero.

We note, in compliance with section 404 of the MMA, in the FY 2022 IPPS/LTCH PPS final rule (86 FR 45194 through 45204), we replaced the 2014-based IPPS operating and capital market baskets with the rebased and revised 2018-based IPPS operating and capital market baskets beginning in FY 2022.

We proposed to base the FY 2023 market basket update used to determine the applicable percentage increase for the IPPS on IHS Global Inc.'s (IGI's) fourth quarter 2021 forecast of the 2018-based IPPS market basket rate-of-increase with historical data through third quarter 2021, which was estimated to be 3.1 percent. We also proposed that if more recent data subsequently became available (for example, a more recent estimate of the market basket update), we would use such data, if appropriate, to determine the FY 2023 market basket update in the final rule.

Comment: Several commenters were concerned the proposed market basket update was not accurately reflecting hospital input inflation citing many examples including ongoing labor shortages, supply chain disruptions, prices for medical equipment, and the impact of Ukraine/Russia war. They urged CMS to adjust its market basket update methodology for FY 2023 to adjust for more recent data and to further adjust its estimate to appropriately capture significant inflationary trends that will further fuel rising hospital operating costs but may not yet be fully captured in IGI's updated market basket forecast in the second quarter of 2022. Commenters requested CMS recognize that hospital inflation will generally lag economy-wide inflation and that the expectations for sustained inflation should be recognized in the projection of the hospital market basket for FY 2023. Several commenters stated the proposed market basket update is a time-lagged estimate that uses historical data to forecast into the future. The commenters stated that when historical data is no longer a good predictor of future changes, the market basket becomes inadequate. A commenter stated that the end of calendar year 2021 into calendar year 2022 should not be considered a steady-state economic environment that is a continuance of past trends. A commenter encouraged CMS to err on the side of steadily increasing inflation into 2023 rather than any material deceleration assumption.

Other commenters urged CMS to rely on more recent forecasts to determine the FY 2023 update. A commenter noted CBO May 2022 baseline projections which had a market basket increase that is 1.1 percentage points higher than the proposed FY 2023 IPPS market basket percentage increase. Several commenters requested that CMS review other inflation data sources such as the Consumer Price Index (CPI) and the core Personal Consumption Expenditures deflator, and suggested that the market basket increase at least match or exceed these rates of increases.

Response: Section 1886(b)(3)(B)(iii) of the Act states the Secretary shall update IPPS payments based on a market basket percentage increase that reflects an index of appropriately weighted indicators of changes in wages and prices that are representative of the mix of goods and services included in such inpatient hospital services. The 2018-based IPPS market basket is a fixed-weight, Laspeyres-type price index that measures the change in price, over time, of the same mix of goods and services purchased by hospitals in the base period. The general inflation measures cited by the commenters would not reflect this same mix of goods and services.

We agree with the commenters that recent higher inflationary trends have impacted the outlook for price growth over the next several quarters. At the time of the FY 2023 IPPS/LTCH PPS proposed rule, based on IGI's fourth quarter 2021 forecast with historical data through third quarter 2021, IGI forecasted the 2018-based IPPS market basket update of 3.1 percent for FY 2023 reflecting forecasted compensation prices of 3.8 percent (by comparison, compensation price growth in the 2018-based IPPS market basket averaged 2.2 percent from 2012–2021). As stated previously, in the FY 2023 IPPS/LTCH PPS proposed rule, we proposed that if more recent data became available, we would use such data, if appropriate, to derive the final FY 2023 IPPS market basket update for the final rule. For this final rule, we now have an updated forecast of the price proxies underlying the market basket that incorporates more recent historical data and reflects a revised outlook regarding the U.S. economy (including the more recent historical CPI growth, impacts of the Russia/Ukraine war, current expectations regarding changes to Federal Reserve interest rates, and tight labor markets). Based on IGI's second quarter 2022 forecast with historical data through first quarter 2022, we are projecting a FY 2023 IPPS market basket update of 4.1 percent (reflecting forecasted compensation price growth of 4.8 percent) and productivity adjustment of 0.3 percentage point. Therefore, as discussed further in this section and after consideration of the comments received, for FY 2023, the final applicable percentage increase for a hospital that submitted quality data and is a meaningful EHR user is 3.8 percent (4.1 percent less 0.3 percentage point), compared to the 2.7 percent that was proposed. We note that the final FY 2023 IPPS market basket growth rate of 4.1 percent would be the highest market basket update implemented in an IPPS final rule going back to FY 1998.

Comment: Several commenters suggested that CMS use alternative sources of data that they stated better reflect input price inflation to calculate the FY 2023 market basket update. A commenter stated that in absence of such data, CMS is urged to consider an alternative approach to better align the market basket updates with increases in the costs needed to care for Medicare beneficiaries. Several commenters encouraged CMS to implement a higher market basket update than proposed, reflecting alternative sources of cost data such as the Medicare cost reports. A commenter requested that CMS provide a market basket update of at least 5 percent.

Several commenters proposed that CMS apply a market basket increase of approximately 8 percent representing estimated trends in allowable Medicare costs per risk-adjusted discharge from the Medicare cost reports from FY 2019 to FY 2020. To support this method, commenters provided the language in the IPPS statute and stated that they believe that Medicare cost report data meets the statutory requirement as these data capture all allowable costs, including personnel costs and excluding non-operating costs that comprise routine, ancillary, and special care unit inpatient hospital services. The commenter stated that given that these data comprise all the costs—on a volume and risk-adjusted basis—necessary to deliver hospital care it represents "appropriately weighted indicators of changes in wages and prices which are representative of the mix of good and services . . ." necessary to provide inpatient hospital care to Medicare beneficiaries. Commenters stated their belief that Medicare cost report data are a more

accurate projection of the cost inflation anticipated by hospitals during FY 2023 than the forecast IGI data used in the proposed rule. The commenters further noted that changes in volume and intensity are accounted for in the market basket update when CMS rebases or revises it, which they stated is infrequent, typically occurring once every four years. They believe their proposed methodology of using Medicare cost report data would fully account for changes in volume and acuity annually, thus resulting in a more accurate proxy.

Another commenter analyzed Medicare cost report data and found that compensation costs increased by more than the IPPS market basket updates of 3.0 percent and 2.4 percent for FYs 2020 and 2021, respectively. The commenter recommended that CMS adjust the IGI compensation price indices and the overall inpatient price indices based on the percent change in compensation costs as derived from the Medicare cost reports.

A commenter recommended that CMS use its exceptions and adjustments authority to substitute Premier Inc. data for the IGI forecast to provide hospitals with an increased payment update in FY 2023 to accurately reflect labor costs. Additionally, the commenter recommended that CMS' Office of the Actuary reevaluate the data sources that it uses for calculating labor costs and consider adopting new or supplemental data sources in future rulemaking that more accurately reflect the cost of labor, such as more real time data from the hospital community. While the commenter stated that they were unable to forecast a market basket update for FY 2023, they noted the substantial impact a 10 percent increase in the labor components would have on the historical market basket for FY 2021, increasing the estimate by several percentage points under this hypothetical scenario.

Response: We believe the 2018-based IPPS market basket increase adequately reflects the average change in the price of goods and services hospitals purchase in order to provide IPPS medical services, and is technically appropriate to use as the market basket percentage increase in accordance with section 1886(b)(3)(B)(iii). As described in the FY 2022 IPPS/LTCH PPS final rule (86 FR 45194 through 45213), the IPPS market basket is a fixed-weight, Laspeyres-type index that measures price changes over time and would not reflect increases in costs associated with changes in the volume or intensity of input goods and services. As such, the IPPS market basket increase would reflect the prospective price pressures described by the commenters as increasing during a high inflation period (such as faster wage price growth or higher energy prices), but would inherently not reflect other factors that might increase the level of costs, such as the quantity of labor used or any shifts between contract and staff nurses (which would be reflected in the Medicare cost report data). We note that cost changes (that is, the product of price and quantities) would only be captured in the market basket weights when the index is rebased and the base year is updated to a more recent time period.

We disagree with the commenters that costs as reported on the Medicare cost report are suitable for determining the trend in compensation prices for the market basket update. Section 1886(b)(3)(B)(iii) of the Act states the Secretary shall estimate a market basket percentage increase based on an index of appropriately weighted indicators of changes in wages and prices which are representative of the mix of goods and services included in such inpatient hospital services. While the current IPPS market basket percentage increase captures price changes associated with the goods and services hospitals purchase in providing care, the Medicare cost report data also reflects factors that are beyond those that impact wage or price growth. For instance, overall costs as reported by hospitals would also reflect changes in the mix of inputs used to provide services; since 2020, observed IPPS case-mix (and associated higher payments to hospitals) has increased faster than in prior years and would likely reflect the use of more skilled care needed to provide these services.

Regarding commenters' request that CMS consider other methods and data sources to calculate the final rule market basket update, we believe the 2018-based IPPS market basket continues to appropriately reflect IPPS cost structures and we believe the price proxies used (such as those from BLS that reflect wage and benefit price growth) are an appropriate representation of price changes for the inputs used by hospitals in providing services. We further note that we did not propose to use other methods or data sources to calculate the final market basket update for FY 2023. Consistent with our proposal, we have used more recent historical data and an updated forecast (that reflects a revised inflationary outlook) to calculate a final IPPS market basket percentage increase for FY 2023 of 4.1 percent, which is one percentage point higher than the proposed market basket percentage increase of 3.1 percent set forth in the FY 2023 IPPS/LTCH PPS proposed rule.

Comment: Several commenters also expressed concerns regarding the use of BLS' Employment Cost Index (ECI), which accounts for 53 percent of the market basket, stating it did not accurately reflect hospitals' compensation costs after the labor market changes triggered by the PHE. A commenter stated that this claim can be evidenced by comparing growth in labor costs from the Medicare cost report data to the ECI growth. The commenters also state that hospitals have faced a shortage of local labor as the PHE has progressed and have had to increasingly turn to contract labor, particularly for the nursing professions, which in turn has contributed to increased compensation costs. The commenters noted that CMS's proposed market basket update reflected a 3.8 percent increase in compensation, which they believe does not accurately reflect changes in current labor costs that they believe are not transitory.

Commenters noted that the ECI does not capture inflation in contract labor compensation while the hospital market basket does include contract labor costs when calculating the compensation cost weights and stated that including the contract labor costs along with other compensation costs assumes contract labor compensation growth will grow at the same rate as non-contract labor compensation. The commenters stated that this assumption is not supported by evidence citing published studies. Commenters also noted analysis by Premier Inc., which showed faster hourly labor rates than the ECI for FY 2021.

Response: As previously discussed, section 1886(b)(3)(B)(iii) of the Act states the Secretary shall estimate a market basket percentage increase based on an index of appropriately weighted indicators of changes in wages and prices which are representative of the mix of goods and services included in such inpatient hospital services. The 2018-based IPPS market basket is a fixed-weight, Laspeyres-type price index that measures the change in price, over time, of the same mix of goods and services purchased in the base period. Any changes in the quantity or mix of goods and services (that is, intensity) purchased over time relative to a base period are not measured. This type of IPPS market basket has been in place since the implementation of the IPPS as well as used for other CMS market baskets.

For the compensation cost weight in the 2018-based IPPS market basket (which includes salaried and contract

labor employees), we use the ECI for wages and salaries and benefits for all civilian hospital workers to proxy the price increases of labor for IPPS hospitals. The ECI (published by the BLS) measures the change in the hourly labor cost to employers, independent of the influence of employment shifts among occupations and industry categories. We note that the Medicare cost report data shows contract labor hours account for about 3 percent of total compensation hours (reflecting employed and contract labor staff) for IPPS hospitals in 2020. Data through 2021 are incomplete at this time. Therefore, while we acknowledge that the ECI measures only reflect price changes for employed staff, we believe that the ECI for hospital workers is accurately reflecting the price change associated with the labor used to provide hospital care (as employed workers' hours account for 97 percent of hospital compensation hours) and appropriately does not reflect other factors that might affect labor costs. Therefore, we believe it continues to be an appropriate measure to use in the IPPS market basket. We also note that based on IGI's second quarter 2022 forecast with historical data through first quarter 2022, compensation price growth (using the ECIs) for FY 2023 is now projected to be 4.8 percent, which is 1.0 percentage point higher than projected price growth at the time of the FY 2023 IPPS/LTCH PPS proposed rule (3.8 percent).

Comment: A commenter encouraged CMS to consider whether additional changes are needed regarding the rebasing and revising of the market basket, given data from 2018 was relied upon in the FY 2022 IPPS/LTCH PPS final rule to determine the appropriate mix of goods and services, which may have been impacted by COVID–19. For example, they stated that during the pandemic there has been increased use of personal protective equipment, yet this utilization would not be captured in the market basket, which was rebased and revised in the FY 2022 IPPS/LTCH PPS final rule.

Response: As described previously, the IPPS market basket measures price changes (including changes in the prices for wages and salaries) over time and would not reflect increases in costs associated with changes in the volume or intensity of input goods and services until the market basket is rebased. The IPPS market basket was last rebased in the FY 2022 IPPS/LTCH PPS final rule using 2018 Medicare cost reports (86 FR 45194 through 45207), the most recent year of complete data available at the time of the rebasing. We note that we did not propose to rebase the IPPS market basket in the FY 2023 IPPS/LTCH PPS proposed rule. However, we did review more recent Medicare cost report data available for IPPS hospitals submitted as of March 2022, which includes data for 2019–2020. The Medicare cost report data (which does not allow us to separately identify costs for-PPE) showed slight decreases in the compensation cost weight in 2019 and 2020 resulting in a compensation cost weight that is roughly 1 percentage point less than the 2018-based IPPS market basket cost weight. Data through 2021 are incomplete at this time. The data also showed slight increases over the 2018 to 2020 time period in the pharmaceuticals cost weight and home office cost weight of about 0.3 percentage point each. Based on this preliminary analysis, the impact on the cost weights through 2020 are minimal and it is unclear whether these trends (particularly the compensation cost weight) through 2020 are reflective of sustained shifts in the cost structure for hospitals or whether they were temporary as a result of the PHE. Therefore, we continue to believe it is premature at this time to use more recent Medicare cost report data to derive a rebased and revised IPPS market basket. We will continue to monitor these data and any changes to the IPPS market basket will be proposed in future rulemaking.

Comment: Several commenters expressed concerns about the market basket update calculations. Commenters stated that CMS calculates the percent change by dividing the average input price indices in the most recent four quarters by the average input price index in the previous four quarters as derived from the most recently available IGI forecast. However, the commenter stated that CMS does not consider the difference between the base year estimates (from the time when prior year payment rates are finalized) and updated estimates of the base year indices since the prior year's market basket update calculation. Therefore, they stated this current update method does not account for substantial forecast errors driven by an unusually fast acceleration of the inflation rate such as occurred in FY 2021. They urge CMS to leverage its exceptions and adjustments authority under section 1886(d)(5)(I)(i) of the Act to modify its methodology for FY 2023 to account for the substantial forecast error in FYs 2021 and 2022. A commenter added that it believes the understatement of the hospital market basket for FY 2021 and FY 2022 and potentially FY 2023 as well is such an occasion for using the exceptions and adjustments authority. The commenter stated that Premier data collected directly from hospitals is showing a 10 percent increase in 2022 to date for hospital compensation (67.6 percent of the market basket) compared to the 3.8 percent being forecasted by IGI. The commenter recommended CMS make a one-time only forecast error correction on the FY 2021 and FY 2022 market basket of a combined 1.9 percentage points for FY 2023 using the exceptions and adjustments authority. The commenter also recommended that CMS use its exceptions and adjustments authority to substitute Premier data for the IGI forecast to provide hospitals with an increased payment update in FY 2023 to accurately reflect labor costs.

A commenter urged CMS to consider a one-time adjustment to ensure that the FY 2023 rate increase is applied to a base rate that more accurately incorporates actual inflation during the pandemic. The commenter cited the unprecedented nature of the pandemic and its extraordinary impact on hospital costs alongside record inflation for the basis of this one-time adjustment.

Response: Section 1886(b)(3)(B) of the Act sets forth the update to the standardized amounts based on the applicable percentage increase. Although the statute does not include a forecast error adjustment, commenters requested that CMS use its exceptions and adjustments authority under section 1886(d)(5)(I)(i) of the Act to modify its methodology to account for the forecast error in FYs 2021 and 2022. We note that we did not propose to use our authority under section 1886(d)(5)(I)(i) of the Act to apply a forecast correction in updating the IPPS rates for FY 2023. While there is no precedent to adjust for market basket forecast error in the IPPS operating payment update, the forecast error for a market basket update is equal to the actual market basket increase for a given year less the forecasted market basket increase. Due to the uncertainty regarding future price trends, forecast errors can be both positive and negative. For example, the FY 2020 IPPS forecast error was −1.0 percentage point, and the FY 2021 IPPS forecast error was +0.7 percentage point; FY 2022 historical data are not yet available to calculate a forecast error for FY 2022. As we have discussed in past rulemaking, we believe that an important goal of a PPS is predictability. For these reasons, we do not believe it is appropriate to include adjustments to the market basket update for future years based on the difference between the actual and forecasted market basket increase in prior years. With regard to the comment

recommending the use of the Premier data, we refer to our response to this comment as previously discussed earlier in this section, regarding why we believe the 2018-based IPPS market basket increase adequately reflects the average change in the price of goods and services hospitals purchase in order to provide IPPS medical services, and is technically appropriate to use as the market basket percentage increase in accordance with section 1886(b)(3)(B)(iii).

We thank the commenters for their comments. After consideration of the comments received and consistent with our proposal, we are finalizing to use more recent data to determine the FY 2023 market basket update for the final rule. Specifically, based on more recent data available, we determined final applicable percentage increases to the standardized amount for FY 2023, as specified in the table that appears later in this section.

In the FY 2012 IPPS/LTCH PPS final rule (76 FR 51689 through 51692), we finalized our methodology for calculating and applying the productivity adjustment. As we explained in that rule, section 1886(b)(3)(B)(xi)(II) of the Act, as added by section 3401(a) of the Affordable Care Act, defines this productivity adjustment as equal to the 10-year moving average of changes in annual economy-wide, private nonfarm business MFP (as projected by the Secretary for the 10-year period ending with the applicable fiscal year, year, cost reporting period, or other annual period). The U.S. Department of Labor's Bureau of Labor Statistics (BLS) publishes the official measures of private nonfarm business productivity for the U.S. economy. We note that previously the productivity measure referenced in section 1886(b)(3)(B)(xi)(II) was published by BLS as private nonfarm business multifactor productivity. Beginning with the November 18, 2021 release of productivity data, BLS replaced the term multifactor productivity (MFP) with total factor productivity (TFP). BLS noted that this is a change in terminology only and will not affect the data or methodology. As a result of the BLS name change, the productivity measure referenced in section 1886(b)(3)(B)(xi)(II) is now published by BLS as private nonfarm business total factor productivity. However, as mentioned, the data and methods are unchanged. Please see *www.bls.gov* for the BLS historical published TFP data. A complete description of IGI's TFP projection methodology is available on the CMS website at *https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/MarketBasketResearch*. In addition, we note that beginning with the FY 2022 IPPS/LTCH PPS final rule, we refer to this adjustment as the productivity adjustment rather than the MFP adjustment to more closely track the statutory language in section 1886(b)(3)(B)(xi)(II) of the Act. We note that the adjustment continues to rely on the same underlying data and methodology.

For FY 2023, we proposed a productivity adjustment of 0.4 percent. Similar to the proposed market basket update, for the proposed rule, the estimate of the proposed FY 2023 productivity adjustment was based on IGI's fourth quarter 2021 forecast. As noted previously, we proposed that if more recent data subsequently became available, we would use such data, if appropriate, to determine the FY 2023 productivity adjustment for the final rule.

Comment: Several commenters requested that CMS use its ''special exceptions and adjustments'' authority under section 1886(d)(5)(I)(i) of the Act to eliminate the productivity adjustment for FY 2023. A commenter requested that CMS work with Congress to permanently eliminate the productivity adjustment to the annual hospital payment updates. Another commenter stated that, if CMS does not use more recent figures from BLS on economy-wide non-farm total factor productivity when determining the adjustment to the IPPS market basket update for FY 2023, then the highly unusual circumstances of the COVID–19 pandemic are sufficient reason for the Secretary to invoke section 1886(d)(5)(I)(i) ''exceptions and adjustments'' authority to provide a one-time adjustment that offsets application of the otherwise applicable productivity adjustment for FY 2023.

A commenter requested that CMS use its ''exceptions and adjustments'' authority under section 1886(d)(5)(I)(i) of the Act to remove the productivity adjustment for any fiscal year that was covered under PHE determination (for example, 2020, 2021, and 2022) from the calculation of market basket update for FY 2023 and any year thereafter.

A commenter recommended that CMS withhold the proposed −0.4 percent productivity adjustment until a federal fiscal year in which hospitals are not operating under the public health emergency (PHE).

Response: While we appreciate the commenters' concerns, section 1886(b)(3)(B)(xi)(I) of the Act requires the application of the productivity adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act to the IPPS market basket update when determining the applicable percentage increase. Section 1886(d)(5)(I)(i) of the Act authorizes the Secretary to provide by regulation for such other exceptions and adjustments to the payment amounts under section 1886(d) of the Act as the Secretary deems appropriate.

We further note that we did not propose to use our authority under section 1886(d)(5)(I)(i) of the Act in the FY 2023 IPPS/LTCH PPS proposed rule to offset the productivity adjustment for FY 2023. Based on the updated forecast for this final rule, and as discussed elsewhere, we are projecting a FY 2023 IPPS market basket update of 4.1 percent and a productivity adjustment of 0.3 percentage point for this final rule, as compared to the proposed market basket update of 3.1 percent and proposed productivity adjustment of 0.4 percentage point set forth in the proposed rule. Additionally, we note Congress has provided other funding to providers as a result of the COVID–19 PHE. Specifically, the CARES Act provided additional payments for cases of COVID–19 under the IPPS and also created the Provider Relief Fund to reimburse providers, including IPPS providers, for increased expenses or lost revenue attributable to COVID–19.

We thank the commenters for their comments. However, as previously noted, section 1886(b)(3)(B)(xi)(II) of the Act, as added by section 3401(a) of the Affordable Care Act, requires a productivity adjustment to the IPPS market basket update when determining the applicable percentage increase. Consistent with our proposal, we are using more recent data to determine the FY 2023 productivity adjustment for the final rule. Specifically, based on IGI's second quarter 2022 forecast, we are projecting a FY 2023 IPPS market basket update of 4.1 percent and productivity adjustment of 0.3 percentage point. Therefore, as discussed further in this section and after consideration of the comments received, for FY 2023, the final IPPS applicable percentage increase for a hospital that submitted quality data and is a meaningful EHR user is 3.8 percent (4.1 percent less 0.3 percentage point).

Comment: Several commenters expressed concerns about the productivity adjustment. A commenter stated that the measure of productivity used by CMS is intended to ensure payments more accurately reflect the true cost of providing patient care and effectively assumes the hospital field can mirror productivity gains across the

private nonfarm business sector. Several commenters stated that this has not been their experience during the pandemic. Commenters also stated that even before the pandemic, CMS Office of the Actuary questioned the wisdom of the underlying assumption in their analysis that compares private non-farm total factor productivity growth measure and a hospital-specific measure (*https://www.cms.gov/files/document/productivity-memo.pdf*). Commenters also stated that the latest data indicates a decrease in productivity, not gains, citing the latest BLS release of labor productivity data. Commenters had strong concerns about the proposed productivity adjustment given the extreme and uncertain circumstances in which their hospitals and health systems are currently operating. Several commenters requested CMS use the latest BLS data when determining the productivity adjustment for FY 2023.

Response: Section 1886(b)(3)(B)(xi)(II) of the Act requires the productivity adjustment be equal to the 10-year moving average of changes in annual economy-wide private nonfarm business total factor productivity (as projected by the Secretary for the 10-year period ending with the applicable fiscal year, year, cost reporting period, or other annual period). For the FY 2023 IPPS/LTCH PPS proposed rule, based on IGI's fourth quarter 2021 forecast, the productivity adjustment was projected to be 0.4 percentage point for FY 2023. For this final rule, based on IGI's second quarter 2022 forecast, we are updating the productivity adjustment to reflect more recent historical data as published by BLS as well as a revised economic outlook for FY 2022 and FY 2023. Using this more recent forecast, the FY 2023 productivity adjustment based on the 10-year moving average growth in economy-wide total factor productivity for the period ending FY 2023 is currently estimated to be 0.3 percent.

We thank the commenters for their comments. After consideration of the comments received and consistent with our proposal, we are finalizing as proposed to use more recent data to determine the FY 2023 productivity adjustment for the final rule.

Based on more recent data available for this FY 2023 IPPS/LTCH PPS final rule (that is, IGI's second quarter 2022 forecast of the 2018-based IPPS market basket rate-of-increase with historical data through the first quarter of 2022), we estimate that the FY 2023 market basket update used to determine the applicable percentage increase for the IPPS is 4.1 percent. Based on more recent data available for this FY 2023 IPPS/LTCH PPS final rule (that is, IGI's second quarter 2022 forecast of the productivity adjustment), the current estimate of the productivity adjustment for FY 2023 is 0.3 percentage point.

As previously discussed, based on the more recent data available, for this final rule, we have determined four final applicable percentage increases to the standardized amount for FY 2023. For FY 2023, depending on whether a hospital submits quality data under the rules established in accordance with section 1886(b)(3)(B)(viii) of the Act (hereafter referred to as a hospital that submits quality data) and is a meaningful EHR user under section 1886(b)(3)(B)(ix) of the Act (hereafter referred to as a hospital that is a meaningful EHR user), there are four possible applicable percentage increases that can be applied to the standardized amount, as specified in this table.

FY 2023 APPLICABLE PERCENTAGE INCREASES FOR THE IPPS

FY 2023	Hospital Submitted Quality Data and is a Meaningful EHR User	Hospital Submitted Quality Data and is NOT a Meaningful EHR User	Hospital Did NOT Submit Quality Data and is a Meaningful EHR User	Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User
Market Basket Rate-of-Increase	4.1	4.1	4.1	4.1
Adjustment for Failure to Submit Quality Data under Section 1886(b)(3)(B)(viii) of the Act	0	0	-1.025	-1.025
Adjustment for Failure to be a Meaningful EHR User under Section 1886(b)(3)(B)(ix) of the Act	0	-3.075	0	-3.075
Productivity Adjustment under Section 1886(b)(3)(B)(xi) of the Act	-0.3	-0.3	-0.3	-0.3
Applicable Percentage Increase Applied to Standardized Amount	**3.8**	**0.725**	**2.775**	**-0.3**

In the FY 2020 IPPS/LTCH PPS final rule (84 FR 42344), we revised our regulations at 42 CFR 412.64(d) to reflect the current law for the update for FY 2020 and subsequent fiscal years. Specifically, in accordance with section 1886(b)(3)(B) of the Act, we added paragraph (d)(1)(viii) to § 412.64 to set forth the applicable percentage increase to the operating standardized amount for FY 2020 and subsequent fiscal years as the percentage increase in the market basket index, subject to the reductions specified under § 412.64(d)(2) for a hospital that does not submit quality data and § 412.64(d)(3) for a hospital that is not a meaningful EHR user, less a productivity adjustment. (As previously noted, section 1886(b)(3)(B)(xii) of the Act required an additional reduction each year only for FYs 2010 through 2019.)

Section 1886(b)(3)(B)(iv) of the Act provides that the applicable percentage increase to the hospital-specific rates for SCHs equals the applicable percentage increase set forth in section 1886(b)(3)(B)(i) of the Act (that is, the same update factor as for all other hospitals subject to the IPPS). Therefore, the update to the hospital-specific rates for SCHs also is subject to section 1886(b)(3)(B)(i) of the Act, as amended by sections 3401(a) and 10319(a) of the Affordable Care Act.

Under current law, the MDH program is effective for discharges on or before September 30, 2022, as discussed in the FY 2019 IPPS/LTCH PPS final rule (83 FR 41429 through 41430). Therefore, under current law, the MDH program will expire at the end of FY 2022. We

refer readers to section V.D. of the preamble of this final rule for further discussion of the expiration of the MDH program.

For FY 2023, we proposed the following updates to the hospital-specific rates applicable to SCHs: a proposed update of 2.7 percent for a hospital that submits quality data and is a meaningful EHR user; a proposed update of 0.375 percent for a hospital that submits quality data and is not a meaningful EHR user; a proposed update of 1.925 percent for a hospital that fails to submit quality data and is a meaningful EHR user; and a proposed update of −0.4 percent for a hospital that fails to submit quality data and is not an meaningful EHR user. We proposed that if more recent data subsequently became available (for example, a more recent estimate of the market basket update and the productivity adjustment), we would use such data, if appropriate, to determine the update in the final rule.

We did not receive any public comments on our proposed updates to hospital-specific rates applicable to SCHs. The general comments we received on the proposed FY 2023 update (including the proposed market basket update and productivity adjustment) are discussed earlier in this section. For FY 2023, we are finalizing the proposal to determine the update to the hospital specific rates for SCHs in this final rule using the more recent available data, as previously discussed.

For this final rule, based on more recent available data, we are finalizing the following updates to the hospital specific rates applicable to SCHs: An update of 3.8 percent for a hospital that submits quality data and is a meaningful EHR user; an update of 0.725 percent for a hospital that submits quality data and is not a meaningful EHR user; an update of 2.775 percent for a hospital that fails to submit quality data and is a meaningful EHR user; and an update of −0.3 percent for a hospital that fails to submit quality data and is not a meaningful EHR user.

2. FY 2023 Puerto Rico Hospital Update

Section 602 of Public Law 114–113 amended section 1886(n)(6)(B) of the Act to specify that subsection (d) Puerto Rico hospitals are eligible for incentive payments for the meaningful use of certified EHR technology, effective beginning FY 2016. In addition, section 1886(n)(6)(B) of the Act was amended to specify that the adjustments to the applicable percentage increase under section 1886(b)(3)(B)(ix) of the Act apply to subsection (d) Puerto Rico hospitals that are not meaningful EHR users, effective beginning FY 2022. Accordingly, for FY 2022, section 1886(b)(3)(B)(ix) of the Act in conjunction with section 602(d) of Public Law 114–113 requires that any subsection (d) Puerto Rico hospital that is not a meaningful EHR user as defined in section 1886(n)(3) of the Act and not subject to an exception under section 1886(b)(3)(B)(ix) of the Act will have ''three-quarters'' of the applicable percentage increase (prior to the application of other statutory adjustments), or three-quarters of the applicable market basket rate-of-increase, reduced by 33⅓ percent. The reduction to three-quarters of the applicable percentage increase for subsection (d) Puerto Rico hospitals that are not meaningful EHR users increases to 66⅔ percent for FY 2023, and, for FY 2024 and subsequent fiscal years, to 100 percent. (We note that section 1886(b)(3)(B)(viii) of the Act, which specifies the adjustment to the applicable percentage increase for ''subsection (d)'' hospitals that do not submit quality data under the rules established by the Secretary, is not applicable to hospitals located in Puerto Rico.) The regulations at 42 CFR 412.64(d)(3)(ii) reflect the current law for the update for subsection (d) Puerto Rico hospitals for FY 2022 and subsequent fiscal years. In the FY 2019 IPPS/LTCH PPS final rule, we finalized the payment reductions (83 FR 41674).

For FY 2023, consistent with section 1886(b)(3)(B) of the Act, as amended by section 602 of Public Law 114–113, we are setting the applicable percentage increase for Puerto Rico hospitals by applying the following adjustments in the following sequence. Specifically, the applicable percentage increase under the IPPS for Puerto Rico hospitals will be equal to the rate of-increase in the hospital market basket for IPPS hospitals in all areas, subject to a 66⅔ percent reduction to three-fourths of the applicable percentage increase (prior to the application of other statutory adjustments; also referred to as the market basket update or rate-of-increase (with no adjustments)) for Puerto Rico hospitals not considered to be meaningful EHR users in accordance with section 1886(b)(3)(B)(ix) of the Act, and then subject to the productivity adjustment at section 1886(b)(3)(B)(xi) of the Act. As noted previously, section 1886(b)(3)(B)(xi) of the Act states that application of the productivity adjustment may result in the applicable percentage increase being less than zero.

Based on IGI's fourth quarter 2021 forecast of the 2018-based IPPS market basket update with historical data through third quarter 2021, in the FY 2023 IPPS/LTCH PPS proposed rule, in accordance with section 1886(b)(3)(B) of the Act, as discussed previously, for Puerto Rico hospitals we proposed a market basket update of 3.1 percent and a productivity adjustment of 0.4 percent. Therefore, for FY 2023, depending on whether a Puerto Rico hospital is a meaningful EHR user, we stated there would be two possible proposed applicable percentage increases that could be applied to the standardized amount. Based on these data, we determined the following proposed applicable percentage increases to the standardized amount for FY 2023 for Puerto Rico hospitals:

- For a Puerto Rico hospital that is a meaningful EHR user, we proposed an applicable percentage increase to the FY 2023 operating standardized amount of 2.7 percent (that is, the FY 2023 estimate of the proposed market basket rate-of-increase of 3.1 percent less an adjustment of 0.4 percentage point for the proposed productivity adjustment).
- For a Puerto Rico hospital that is not a meaningful EHR user, we proposed an applicable percentage increase to the operating standardized amount of 1.15 percent (that is, the FY 2023 estimate of the proposed market basket rate-of-increase of 3.1 percent, less an adjustment of 1.55 percentage point (the proposed market basket rate-of-increase of 3.1 percent × 0.75 × (⅔) for failure to be a meaningful EHR user), and less an adjustment of 0.4 percentage point for the proposed productivity adjustment).

We did not receive any public comments on our proposed updates to the standardized amount for FY 2023 for Puerto Rico hospitals. The general comments we received on the proposed FY 2023 update (including the proposed market basket update and productivity adjustment) are discussed in greater detail earlier in this section. For FY 2023, we are finalizing the proposal to determine the update to the standardized amount for FY 2023 for Puerto Rico hospitals in this final rule using the more recent available data, as previously discussed.

As previously discussed in section V.A.1, based on more recent data available for this final rule (that is, IGI's second quarter 2022 forecast of the 2018-based IPPS market basket rate-of-increase with historical data through the first quarter of 2022), we estimate that the FY 2023 market basket update used to determine the applicable percentage increase for the IPPS is 4.1 percent and the productivity adjustment is 0.3 percent. For FY 2023, depending on whether a Puerto Rico hospital is a meaningful EHR user, there are two

possible applicable percentage increases that can be applied to the standardized amount. Based on these data, accordance with section 1886(b)(3)(B) of the Act, we determined the following applicable percentage increases to the standardized amount for FY 2023 for Puerto Rico hospitals:

- For a Puerto Rico hospital that is a meaningful EHR user, an applicable percentage increase to the FY 2023 operating standardized amount of 3.8 percent (that is, the FY 2023 estimate of the market basket rate-of-increase of 4.1 percent less an adjustment of 0.3 percentage point for the productivity adjustment).
- For a Puerto Rico hospital that is not a meaningful EHR user, an applicable percentage increase to the operating standardized amount of 1.75 percent (that is, the FY 2023 estimate of the market basket rate-of-increase of 4.1 percent, less an adjustment of 2.05 percentage point (the market basket rate-of-increase of 4.1 percent × 0.75 × (2⁄3) for failure to be a meaningful EHR user), and less an adjustment of 0.3 percentage point for the productivity adjustment).

FY 2023 APPLICABLE PERCENTAGE INCREASES FOR PUERTO RICO HOSPITALS PAID UNDER THE IPPS

FY 2023	Hospital is a Meaningful EHR User	Hospital is not a Meaningful EHR User
Market Basket Rate-of-Increase	4.1	4.1
Adjustment for Failure to be a Meaningful EHR User under Section 1886(b)(3)(B)(ix) of the Act	0	-2.05
Productivity Adjustment under Section 1886(b)(3)(B)(xi) of the Act	-0.3	-0.3
Applicable Percentage Increase Applied to Standardized Amount	**3.8**	**1.75**

B. Rural Referral Centers (RRCs) Annual Updates to Case-Mix Index (CMI) and Discharge Criteria (§ 412.96)

Under the authority of section 1886(d)(5)(C)(i) of the Act, the regulations at § 412.96 set forth the criteria that a hospital must meet in order to qualify under the IPPS as a rural referral center (RRC). RRCs receive special treatment under both the DSH payment adjustment and the criteria for geographic reclassification.

Section 402 of Public Law 108–173 raised the DSH payment adjustment for RRCs such that they are not subject to the 12-percent cap on DSH payments that is applicable to other rural hospitals. RRCs also are not subject to the proximity criteria when applying for geographic reclassification. In addition, they do not have to meet the requirement that a hospital's average hourly wage must exceed, by a certain percentage, the average hourly wage of the labor market area in which the hospital is located.

Section 4202(b) of Public Law 105–33 states, in part, that any hospital classified as an RRC by the Secretary for FY 1991 shall be classified as such an RRC for FY 1998 and each subsequent fiscal year. In the August 29, 1997, IPPS final rule with comment period (62 FR 45999), we reinstated RRC status for all hospitals that lost that status due to triennial review or MGCRB reclassification. However, we did not reinstate the status of hospitals that lost RRC status because they were now urban for all purposes because of the OMB designation of their geographic area as urban. Subsequently, in the August 1, 2000 IPPS final rule (65 FR 47089), we indicated that we were revisiting that decision. Specifically, we stated that we would permit hospitals that previously qualified as an RRC and lost their status due to OMB redesignation of the county in which they are located from rural to urban, to be reinstated as an RRC. Otherwise, a hospital seeking RRC status must satisfy all of the other applicable criteria. We use the definitions of ''urban'' and ''rural'' specified in subpart D of 42 CFR part 412. One of the criteria under which a hospital may qualify as an RRC is to have 275 or more beds available for use (§ 412.96(b)(1)(ii)). A rural hospital that does not meet the bed size requirement can qualify as an RRC if the hospital meets two mandatory prerequisites (a minimum case-mix index (CMI) and a minimum number of discharges), and at least one of three optional criteria (relating to specialty composition of medical staff, source of inpatients, or referral volume). (We refer readers to § 412.96(c)(1) through (5) and the September 30, 1988, **Federal Register** (53 FR 38513) for additional discussion.) With respect to the two mandatory prerequisites, a hospital may be classified as an RRC if—

- The hospital's CMI is at least equal to the lower of the median CMI for urban hospitals in its census region, excluding hospitals with approved teaching programs, or the median CMI for all urban hospitals nationally; and
- The hospital's number of discharges is at least 5,000 per year, or, if fewer, the median number of discharges for urban hospitals in the census region in which the hospital is located. The number of discharges criterion for an osteopathic hospital is at least 3,000 discharges per year, as specified in section 1886(d)(5)(C)(i) of the Act.

In the FY 2022 final rule (86 FR 45217), in light of the COVID–19 PHE, we amended the regulations at § 412.96(h)(1) to provide for the use of the best available data rather than the latest available data in calculating the national and regional CMI criteria. We also amended the regulations at § 412.96(c)(1) to indicate that the individual hospital's CMI value for discharges during the same Federal fiscal year used to compute the national and regional CMI values is used for purposes of determining whether a hospital qualifies for RRC classification. We also amended the regulations § 412.96(i)(1) and (2), which describe the methodology for calculating the number of discharges criteria, to provide for the use of the best available data rather than the latest available or most recent data when calculating the regional discharges for RRC classification.

1. Case-Mix Index (CMI)

Section 412.96(c)(1) provides that CMS establish updated national and

regional CMI values in each year's annual notice of prospective payment rates for purposes of determining RRC status. The methodology we used to determine the national and regional CMI values is set forth in the regulations at § 412.96(c)(1)(ii). The national median CMI value for FY 2023 is based on the CMI values of all urban hospitals nationwide, and the regional median CMI values for FY 2023 are based on the CMI values of all urban hospitals within each census region, excluding those hospitals with approved teaching programs (that is, those hospitals that train residents in an approved GME program as provided in § 413.75). For the proposed rule, these values were based on discharges occurring during FY 2021 (October 1, 2020 through September 30, 2021), and include bills posted to CMS' records through December 2021. We believe that this is the best available data for use in calculating the national and regional median CMI values and is consistent with our finalized proposal to use the FY 2021 MedPAR claims data for FY 2023 ratesetting. We refer the reader to section I.F. of the preamble of this final rule for a complete discussion regarding our proposal and finalized policy to use the latest available data (that is, the FY 2021 MedPAR data) as the best available data for purposes of this FY 2023 rulemaking.

In the FY 2023 IPPS/LTCH PPS proposed rule (87 FR 28404), we proposed that, in addition to meeting other criteria, if rural hospitals with fewer than 275 beds are to qualify for initial RRC status for cost reporting periods beginning on or after October 1, 2022, they must have a CMI value for FY 2021 that is at least—

- 1.8251 (national—all urban); or
- The median CMI value (not transfer-adjusted) for urban hospitals (excluding hospitals with approved teaching programs as identified in § 413.75) calculated by CMS for the census region in which the hospital is located.

The proposed median CMI values by region were set forth in a table in the proposed rule (87 FR 28405). We stated in the proposed rule that we intended to update the proposed CMI values in the FY 2023 final rule to reflect the updated FY 2021 MedPAR file, which will contain data from additional bills received through March 2022.

Comment: Commenters supported our proposal to use FY 2021 data to calculate the national and regional median CMI values for FY 2023.

Response: We appreciate the commenters' support.

Therefore, based on the best available data (FY 2021 bills received through March 2022), in addition to meeting other criteria, if rural hospitals with fewer than 275 beds are to qualify for initial RRC status for cost reporting periods beginning on or after October 1, 2022, they must have a CMI value for FY 2021 that is at least:

- 1.8262 (national—all urban); or
- The median CMI value (not transfer-adjusted) for urban hospitals (excluding hospitals with approved teaching programs as identified in § 413.75) calculated by CMS for the census region in which the hospital is located.

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

Region	Case-Mix Index Value
1. New England (CT, ME, MA, NH, RI, VT)	1.4961
2. Middle Atlantic (PA, NJ, NY)	1.59995
3. East North Central (IL, IN, MI, OH, WI)	1.7062
4. West North Central (IA, KS, MN, MO, NE, ND, SD)	1.7709
5. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	1.68745
6. East South Central (AL, KY, MS, TN)	1.6754
7. West South Central (AR, LA, OK, TX)	1.8756
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	1.896
9. Pacific (AK, CA, HI, OR, WA)	1.8547

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

3. Discharges

Section 412.96(c)(2)(i) provides that CMS set forth the national and regional numbers of discharges criteria in each year's annual notice of prospective payment rates for purposes of determining RRC status. As specified in section 1886(d)(5)(C)(ii) of the Act, the national standard is set at 5,000 discharges. In the FY 2023 IPPS/LTCH PPS proposed rule (87 FR 28406), for FY 2023, we proposed to update the regional standards based on discharges for urban hospitals' cost reporting periods that began during FY 2020 (that is, October 1, 2019 through September 30, 2020). We believe that this is the best available data for use in calculating the median number of discharges by region and is consistent with our finalized data proposal to use cost report data from cost reporting periods beginning during FY 2020 for FY 2023 ratesetting. We refer the reader to section I.F. of the preamble of this final rule for a complete discussion regarding our proposal and finalized policy to use the latest available data (that is, cost reports beginning during FY 2020) as the best available data for purposes of this FY 2023 rulemaking.

In the FY 2023 IPPS/LTCH PPS proposed rule (87 FR 28405), we proposed that, in addition to meeting other criteria, a hospital, if it is to qualify for initial RRC status for cost reporting periods beginning on or after October 1, 2022, must have, as the number of discharges for its cost reporting period that began during FY 2020, at least—

- 5,000 (3,000 for an osteopathic hospital); or
- If less, the median number of discharges for urban hospitals in the census region in which the hospital is located. (We refer readers to the table set forth in the FY 2023 IPPS/LTCH PPS proposed rule at 87 FR 28406). In the

proposed rule, we stated that we intended to update to update these numbers in the FY 2023 final rule based on the latest available cost report data.

Comment: Commenters supported our proposal to use FY 2020 data to calculate median number of discharges by region for FY 2023.

Response: We appreciate the commenters' support.

Therefore, based on the best available discharge data at this time, that is, for cost reporting periods that began during FY 2020, the final median number of discharges for urban hospitals by census region are set forth in the following table.

Region	Number of Discharges
1. New England (CT, ME, MA, NH, RI, VT)	8,713
2. Middle Atlantic (PA, NJ, NY)	9,149
3. East North Central (IL, IN, MI, OH, WI)	7,635
4. West North Central (IA, KS, MN, MO, NE, ND, SD)	7,298
5. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	9,833
6. East South Central (AL, KY, MS, TN)	9,206
7. West South Central (AR, LA, OK, TX)	5,747
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	7,693
9. Pacific (AK, CA, HI, OR, WA)	8,087

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

C. Payment Adjustment for Low-Volume Hospitals (§ 412.101)

1. Expiration of Temporary Changes to Low-Volume Hospital Payment Policy

As discussed in the FY 2019 IPPS/LTCH PPS final rule (83 FR 41398 through 41399), section 50204 of the Bipartisan Budget Act of 2018 (Pub. L. 115–123) modified the definition of a low-volume hospital and the methodology for calculating the payment adjustment for low-volume hospitals under section 1886(d)(12) of the Act for FYs 2019 through 2022. Beginning with FY 2023, the low-volume hospital qualifying criteria and payment adjustment will revert to the statutory requirements that were in effect prior to FY 2011, and the preexisting low-volume hospital payment adjustment methodology and qualifying criteria, as implemented in FY 2005 and discussed later in this section of this final rule, will resume. (For additional information on the temporary changes to the low-volume hospital payment policy, we refer readers to the FY 2019 IPPS/LTCH PPS final rule (83 FR 41398 through 41401). We also note, in that same final rule, we amended the regulations at 42 CFR 412.101 to reflect the provisions of section 50204 of the Bipartisan Budget Act of 2018.) We discuss the payment policies for FY 2023 in section V.C.3. of the preamble of this final rule.

2. Background

Section 1886(d)(12) of the Act provides for an additional payment to each qualifying low-volume hospital under the IPPS beginning in FY 2005. The additional payment adjustment to a low-volume hospital provided for under section 1886(d)(12) of the Act is in addition to any payment calculated under section 1886 of the Act. Therefore, the additional payment adjustment is based on the per discharge amount paid to the qualifying hospital under section 1886 of the Act. In other words, the low-volume hospital payment adjustment is based on total per discharge payments made under section 1886 of the Act, including capital, DSH, IME, and outlier payments. For SCHs and MDHs, the low-volume hospital payment adjustment is based in part on either the Federal rate or the hospital-specific rate, whichever results in a greater operating IPPS payment.

As discussed in the FY 2022 IPPS/LTCH PPS final rule (86 FR 45219 through 45221), section 50204 of the Bipartisan Budget Act of 2018 (Pub. L. 115–123) modified the definition of a low-volume hospital and the methodology for calculating the payment adjustment for low-volume hospitals for FYs 2019 through 2022. Specifically, the qualifying criteria for low-volume hospitals under section 1886(d)(12)(C)(i) of the Act were amended to specify that, for FYs 2019 through 2022, a subsection (d) hospital qualifies as a low-volume hospital if it is more than 15 road miles from another subsection (d) hospital and has less than 3,800 total discharges during the fiscal year. Section 1886(d)(12)(D) of the Act was also amended to provide that, for discharges occurring in FYs 2019 through 2022, the Secretary determines the applicable percentage increase using a continuous, linear sliding scale ranging from an additional 25 percent payment adjustment for low-volume hospitals with 500 or fewer discharges to a zero percent additional payment for low-volume hospitals with more than 3,800 discharges in the fiscal year. Consistent with the requirements of section 1886(d)(12)(C)(ii) of the Act, the term ''discharge'' for purposes of these provisions refers to total discharges, regardless of payer (that is, Medicare and non-Medicare discharges).

Beginning with FY 2023, the low-volume hospital qualifying criteria and payment adjustment will revert to the statutory requirements that were in effect prior to FY 2011. Section 1886(d)(12)(C)(i) of the Act defines a low-volume hospital, for FYs 2005 through 2010 and FY 2023 and subsequent years, as a subsection (d) hospital that the Secretary determines is located more than 25 road miles from another subsection (d) hospital and that has less than 800 discharges during the fiscal year. Section 1886(d)(12)(C)(ii) of the Act further stipulates that the term ''discharge'' means an inpatient acute care discharge of an individual, regardless of whether the individual is entitled to benefits under Medicare Part A (except with respect to FYs 2011 through 2018). Therefore, for FYs 2005 through 2010 and FY 2019 and subsequent years, the term ''discharge'' refers to total discharges, regardless of payer (that is, Medicare and non-Medicare discharges), and as such the

term discharge continues to refer to total discharges for FY 2023 and subsequent years. Furthermore, section 1886(d)(12)(B) of the Act requires, for discharges occurring in FYs 2005 through 2010 and FY 2023 and subsequent years, that the Secretary determine an applicable percentage increase for these low-volume hospitals based on the ''empirical relationship'' between the standardized cost-per-case for such hospitals and the total number of discharges of such hospitals and the amount of the additional incremental costs (if any) that are associated with such number of discharges. The statute thus mandates that the Secretary develop an empirically justifiable adjustment based on the relationship between costs and discharges for these low-volume hospitals. Section 1886(d)(12)(B)(iii) of the Act limits the applicable percentage increase adjustment to no more than 25 percent.

Based on an analysis we conducted for the FY 2005 IPPS final rule (69 FR 49099 through 49102), a 25-percent low-volume adjustment to all qualifying hospitals with less than 200 discharges was found to be most consistent with the statutory requirement to provide relief to low-volume hospitals where there is empirical evidence that higher incremental costs are associated with low numbers of total discharges. In the FY 2006 IPPS final rule (70 FR 47432 through 47434), we stated that multivariate analyses supported the existing low-volume adjustment implemented in FY 2005. Accordingly, under the existing regulations, in order for a hospital to continue to qualify as a low-volume hospital on or after October 1, 2022, it must have fewer than 200 total discharges during the fiscal year and be located more than 25 road miles from the nearest ''subsection (d)'' hospital (see § 412.101(b)(2)(i)). (For additional information on the low-volume hospital payment adjustment prior to FY 2018, we refer readers to the FY 2017 IPPS/LTCH PPS final rule (81 FR 56941 through 56943). For additional information on the low-volume hospital payment adjustment for FY 2018, we refer readers to the FY 2018 IPPS notice (CMS–1677–N) that appeared in the April 26, 2018, **Federal Register** (83 FR 18301 through 18308). For additional information on the low-volume hospital payment adjustment for FY 2019 through FY 2022, we refer readers to the FY 2019 IPPS/LTCH PPS final rule (83 FR 41398 through 41399).)

3. Payment Adjustment for FY 2023 and Subsequent Fiscal Years

In accordance with section 1886(d)(12) of the Act, beginning with FY 2023, the low-volume hospital definition and payment adjustment methodology will revert back to the statutory requirements that were in effect prior to the amendments made by the Affordable Care Act and subsequent legislation. Therefore, effective for FY 2023 and subsequent years, under current policy at § 412.101(b), in order to qualify as a low-volume hospital, a subsection (d) hospital must be more than 25 road miles from another subsection (d) hospital and have less than 200 discharges (that is, less than 200 discharges total, including both Medicare and non-Medicare discharges) during the fiscal year. For FY 2023 and subsequent years, the statute specifies that a low-volume hospital must have less than 800 discharges during the fiscal year. However, as required by section 1886(d)(12)(B)(i) of the Act and as discussed earlier, the Secretary has developed an empirically justifiable payment adjustment based on the relationship, for IPPS hospitals with less than 800 discharges, between the additional incremental costs (if any) that are associated with a particular number of discharges. Based on an analysis we conducted for the FY 2005 IPPS final rule (69 FR 49099 through 49102), a 25-percent low-volume adjustment to all qualifying hospitals with less than 200 discharges was found to be most consistent with the statutory requirement to provide relief for low-volume hospitals where there is empirical evidence that higher incremental costs are associated with low numbers of total discharges. (Under the policy we established in that same final rule, hospitals with between 200 and 799 discharges do not receive a low-volume hospital adjustment.)

For FYs 2005 through 2010 and FY 2018 and subsequent years, the discharge determination is made based on the hospital's number of total discharges, that is, Medicare and non-Medicare discharges. The hospital's most recently submitted cost report is used to determine if the hospital meets the discharge criterion to receive the low-volume payment adjustment in the current year (§ 412.101(b)(2)(i)). We use cost report data to determine if a hospital meets the discharge criterion because this is the best available data source that includes information on both Medicare and non-Medicare discharges. We note that, for FYs 2011 through 2018, we used the most recently available MedPAR data to determine the hospital's Medicare discharges because only Medicare discharges were used to determine if a hospital met the discharge criterion for those years.

In addition to the discharge criterion, a hospital must also meet the mileage criterion to qualify for the low-volume payment adjustment. As specified by section 1886(d)(12)(C)(i) of the Act, a low-volume hospital must be more than 25 road miles (or 15 road miles for FYs 2011 through 2022) from another subsection (d) hospital. Accordingly, for FY 2023 and for subsequent fiscal years, in addition to the discharge criterion, the eligibility for the low-volume payment adjustment is also dependent upon the hospital meeting the mileage criterion at § 412.101(b)(2)(i), which specifies that a hospital must be located more than 25 road miles from the nearest subsection (d) hospital, consistent with section 1886(d)(12)(C)(i) of the Act. We define, at § 412.101(a), the term ''road miles'' to mean ''miles'' as defined at § 412.92(c)(1) (75 FR 50238 through 50275 and 50414).

Comment: Several commenters opposed the change to the low-volume hospital policy in FY 2023. Many of those commenters stated that they are concerned about the financial impact resulting from the decrease in payments due to the expiration of the temporary changes to the low-volume hospital payment policy. Some commenters requested that CMS use its authority to extend the use of the modified definition of a low-volume hospital and the methodology for calculating the payment adjustment for low-volume hospitals. Some commenters stated their belief that CMS has the authority to not allow the temporary changes to expire. A commenter requested CMS use its discretion under the Emergency Pandemic Declarations to extend the low-volume hospital payment policy.

Response: We appreciate the commenters' sharing their concerns regarding the financial impact resulting from the expiration of the temporary changes to the low-volume hospital payment policy. As previously discussed, section 1886(d)(12) of the Act sets forth the applicable low-volume hospital policy beginning FY 2023. In response to the comment that requested the temporary changes to the low-volume hospital policy be extended using the discretion under the Emergency Pandemic Declarations, we believe the commenter is referring to the use of waivers under Section 1135 of the Act. While this provision authorizes certain Medicare (and other) program requirements and conditions of participation to be waived during certain emergencies, this authority cannot be used to waive provisions of payment.

Comment: Several commenters support legislative action through the

Rural Hospital Support Act (H.R. 1887/S. 4009) to extend or make permanent the modifications to the low-volume hospital payment policy enacted by section 50204 of the Bipartisan Budget Act of 2018. Many commenters urged CMS to collaborate with Congress to extend or make permanent the modifications to the low-volume hospital payment policy. Other commenters stated that it is not the intent of Congress for the low-volume hospital payment policy to revert back to the historical statutory requirements. Some of these commenters believe that CMS is ignoring the congressional intent of this policy and denying a group of IPPS providers low-volume hospital payments with the reversion to the policy that was originally established for FY 2005. These commenters requested expanding eligibility for the discharge criteria to match the statutory requirement to include IPPS providers with 200–799 discharges. These commenters did not provide any data analysis in support of their comments to expand the low-volume hospital adjustment to qualifying hospitals that have more than 200 and less than 800 total discharges. A commenter requested that CMS update its regression analysis. The commenter stated that empirical justification used by CMS to determine the discharge criteria of less than 200 discharges is dated and that no rationale to support the ongoing validity of the previous analysis was provided in the proposed rule. The commenter also noted that even if the low-volume hospital discharge criteria were expanded to less than 800 total discharges, there would still only be a small number of hospitals to qualify for low-volume payment adjustment.

Response: We appreciate the commenters sharing their support for legislative action. We disagree that is contrary to the congressional intent for the low-volume hospital policy to revert back to the policy established under the original historical statutory requirements. As noted earlier in the preamble of this final rule and as discussed in response to public comments in the FY 2013 IPPS/LTCH PPS final rule (77 FR 53408 through 53409), the FY 2014 IPPS/LTCH PPS final rule (78 50612 through 50613), and the FY 2018 IPPS/LTCH PPS final rule (82 FR 38184 through 38189) to implement the original low-volume hospital payment adjustment provision, and as mandated by statute, we developed an empirically justified adjustment based on the relationship between costs and total discharges of hospitals with less than 800 total (Medicare and non-Medicare) discharges. Specifically, we performed several regression analyses to evaluate the relationship between hospitals' costs per case and discharges, and found that an adjustment for hospitals with less than 200 total discharges is most consistent with the statutory requirement to provide for additional payments to low-volume hospitals where there is empirical evidence that higher incremental costs are associated with lower numbers of discharges (69 FR 49101 through 49102). Based on these analyses, we established a low-volume hospital policy under which qualifying hospitals with less than 200 total discharges receive a payment adjustment of an additional 25 percent. (Section 1886(d)(12)(B)(iii) of the Act limits the applicable percentage increase adjustment to no more than 25 percent.) In the future, we may reevaluate the low-volume hospital adjustment policy; that is, the definition of a low-volume hospital and the payment adjustment. However, we are not aware of any analysis or empirical evidence that would support expanding the originally established low-volume hospital adjustment policy and we did not make any proposals regarding the low-volume hospital payment adjustment for FY 2023. For these reasons, we are not making any changes to the low-volume hospital payment adjustment policy in this final rule.

Comment: Some commenters urged CMS to expedite any changes to the definition of a low-volume hospital and the methodology for calculating the payment adjustment for low-volume hospitals, should Congress extend the current policy. They requested that low-volume hospital payments be restored quickly so that impacted providers are able to continue to provide quality care.

Response: We appreciate the commenters' request and, as in the past, we will make every effort to implement any extension of the low-volume payment policy as expeditiously as possible.

Comment: A commenter questioned how a hospital would qualify for low-volume payments while also adhering to the inpatient hospitals Conditions of Participation (CoP) since only hospitals with less than 200 total discharges would be eligible for the low-volume hospital adjustment beginning in FY 2023. The commenter argues that IPPS hospitals cannot adhere to the average daily census (ADC) and average length of stay (ALOS) thresholds in the discussion of the factors for state agencies to consider when certifying a facility as an inpatient hospital in the State Operations Manual (SOM).[214] Specifically, the commenter cites ''the ALOS of two midnights'' benchmark and the expectation ''to maintain an average daily census (ADC) of two patients.''

Response: While we appreciate the commenter's concern regarding compliance with the COPs and hospitals' certification as an inpatient hospital, it is not clear to us why a low-volume hospital payment adjustment criterion of less than 200 discharges would prevent a hospital from meeting ''the ADC and ALOS thresholds required for maintaining its certification and status as an inpatient facility.'' The low-volume payment adjustment provides an additional payment to hospitals that meet the low-volume hospital qualifying criteria and does not directly impact a hospital's ADC or ALOS. We also note that CMS considers multiple factors when determining certification for inpatient hospitals. ADC and ALOS are factors in determining a hospital's eligibility for specialized payment categories. Hospitals are not required to have any specific number of inpatients for certification. A hospital's ability to adhere to the inpatient hospital CoPs is not relevant to the reversion to the low-volume hospital payment requirements that were in effect prior to FY 2011.

After consideration of the public comments we received, we are finalizing our proposals, without modification. Consistent with current law, effective beginning FY 2023, the low-volume hospital definition and payment adjustment methodology will revert back to the policy established under statutory requirements that were in effect prior to the amendments made by the Affordable Care Act and extended through subsequent legislation (most recently the Bipartisan Budget Act of 2018).

4. Process for Requesting and Obtaining the Low-Volume Hospital Payment Adjustment

In the FY 2011 IPPS/LTCH PPS final rule (75 FR 50238 through 50275 and 50414) and subsequent rulemaking, most recently in the FY 2022 IPPS/LTCH PPS final rule (86 FR 45219 through 45221), we discussed the process for requesting and obtaining the low-volume hospital payment adjustment.

Under this previously established process, a hospital makes a written

[214] *https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-17-44-Revised-102717.pdf.*

request for the low-volume payment adjustment under § 412.101 to its MAC. This request must contain sufficient documentation to establish that the hospital meets the applicable mileage and discharge criteria. The MAC will determine if the hospital qualifies as a low-volume hospital by reviewing the data the hospital submits with its request for low-volume hospital status in addition to other available data. Under this approach, a hospital will know in advance whether or not it will receive a payment adjustment under the low-volume hospital policy. The MAC and CMS may review available data such as the number of discharges, in addition to the data the hospital submits with its request for low-volume hospital status, to determine whether or not the hospital meets the qualifying criteria. (For additional information on our existing process for requesting the low-volume hospital payment adjustment, we refer readers to the FY 2019 IPPS/LTCH PPS final rule (83 FR 41399 through 41401).)

As explained earlier, for FY 2019 and subsequent fiscal years, the discharge determination is made based on the hospital's number of total discharges, that is, Medicare and non-Medicare discharges, as was the case for FYs 2005 through 2010. Under § 412.101(b)(2)(i) and (iii), a hospital's most recently submitted cost report is used to determine if the hospital meets the discharge criterion to receive the low-volume payment adjustment in the current year. As discussed in the FY 2019 IPPS/LTCH PPS final rule (83 FR 41399 and 41400), we use cost report data to determine if a hospital meets the discharge criterion because this is the best available data source that includes information on both Medicare and non-Medicare discharges. (For FYs 2011 through 2018, the most recently available MedPAR data were used to determine the hospital's Medicare discharges because non-Medicare discharges were not used to determine if a hospital met the discharge criterion for those years.) Therefore, a hospital must refer to its most recently submitted cost report for total discharges (Medicare and non-Medicare) to decide whether or not to apply for low-volume hospital status for a particular fiscal year.

As also discussed in the FY 2019 IPPS/LTCH PPS final rule, in addition to the discharge criterion, for FY 2019 and for subsequent fiscal years, eligibility for the low-volume hospital payment adjustment is also dependent upon the hospital meeting the applicable mileage criterion specified in § 412.101(b)(2)(i) or (iii) for the fiscal year. Specifically, to meet the mileage criterion to qualify for the low-volume hospital payment adjustment for FY 2023, a hospital must be located more than 25 road miles from the nearest subsection (d) hospital. (We define in § 412.101(a) the term ''road miles'' to mean ''miles'' as defined in § 412.92(c)(1) (75 FR 50238 through 50275 and 50414).) For establishing that the hospital meets the mileage criterion, the use of a web-based mapping tool as part of the documentation is acceptable. The MAC will determine if the information submitted by the hospital, such as the name and street address of the nearest hospitals, location on a map, and distance from the hospital requesting low-volume hospital status, is sufficient to document that it meets the mileage criterion. If not, the MAC will follow up with the hospital to obtain additional necessary information to determine whether or not the hospital meets the applicable mileage criterion.

In accordance with our previously established process, a hospital must make a written request for low-volume hospital status that is received by its MAC by September 1 immediately preceding the start of the Federal fiscal year for which the hospital is applying for low-volume hospital status in order for the applicable low-volume hospital payment adjustment to be applied to payments for its discharges for the fiscal year beginning on or after October 1 immediately following the request (that is, the start of the Federal fiscal year). For a hospital whose request for low volume hospital status is received after September 1, if the MAC determines the hospital meets the criteria to qualify as a low-volume hospital, the MAC will apply the applicable low-volume hospital payment adjustment to determine payment for the hospital's discharges for the fiscal year, effective prospectively within 30 days of the date of the MAC's low-volume status determination.

Consistent with this previously established process, for FY 2023, we proposed that a hospital must submit a written request for low-volume hospital status to its MAC that includes sufficient documentation to establish that the hospital meets the applicable mileage and discharge criteria (as described earlier). Specifically, for FY 2023, a hospital must make a written request for low-volume hospital status that is received by its MAC no later than September 1, 2022, in order for the 25-percent, low-volume, add-on payment adjustment to be applied to payments for its discharges beginning on or after October 1, 2022. If a hospital's written request for low-volume hospital status for FY 2023 is received after September 1, 2022, and if the MAC determines the hospital meets the criteria to qualify as a low-volume hospital, the MAC would apply the low-volume hospital payment adjustment to determine the payment for the hospital's FY 2023 discharges, effective prospectively within 30 days of the date of the MAC's low-volume hospital status determination.

Under this process, a hospital that qualified for the low-volume hospital payment adjustment for FY 2022 may continue to receive a low-volume hospital payment adjustment for FY 2023 without reapplying if it meets both the discharge criterion and the mileage criterion applicable for FY 2023. As discussed previously, for FY 2023 the discharge and the mileage criteria are reverting to the statutory requirements that were in effect prior to FY 2011, and to the preexisting low-volume hospital qualifying criteria, as implemented in FY 2005 and specified in the existing regulations at § 412.101(b)(2)(i). As in previous years, we proposed that such a hospital must send written verification that is received by its MAC no later than September 1, 2022, stating that it meets the mileage criterion applicable for FY 2023 (that is, is located more than 25 road miles from the nearest ''subsection (d)'' hospital). For FY 2023, we further proposed that this written verification must also state, based upon the most recently submitted cost report, that the hospital meets the discharge criterion applicable for FY 2023 (that is, less than 200 discharges total, including both Medicare and non-Medicare discharges). If a hospital's request for low-volume hospital status for FY 2023 is received after September 1, 2022, and if the MAC determines the hospital meets the criteria to qualify as a low-volume hospital, the MAC will apply the 25-percent, low-volume, add-on payment adjustment to determine the payment for the hospital's FY 2023 discharges, effective prospectively within 30 days of the date of the MAC's low-volume hospital status determination.

We received no comments on our proposed process for requesting and obtaining the low-volume hospital payment adjustment for FY 2023 and therefore are finalizing this proposal without modification.

We note, in the FY 2019 IPPS/LTCH PPS final rule (83 FR 41398 through 41401 and 41702), in accordance with the provisions of section 50204 of the Bipartisan Budget Act of 2018, for FY 2023 and subsequent fiscal years, we made conforming changes to the regulations at 42 CFR 412.101 to reflect that the low-volume payment adjustment policy in effect for these

years is the same low-volume hospital payment adjustment policy in effect for FYs 2005 through 2010. Under these revisions, beginning with FY 2023, consistent with current law, the low-volume hospital qualifying criteria and payment adjustment methodology will return to the criteria and methodology that were in effect prior to the amendments made by the Affordable Care Act (that is, the low-volume hospital payment policy in effect for FYs 2005 through 2010). Therefore, no further revisions to the policy or to the regulations at § 412.101 are required to conform them to the statutory requirement that the low-volume hospital policy in effect prior to the Affordable Care Act will again be in effect for FY 2023 and subsequent years.

D. Changes in the Medicare-Dependent, Small Rural Hospital (MDH) Program (§ 412.108)

1. Background for the MDH Program

Section 1886(d)(5)(G) of the Act provides special payment protections, under the IPPS, to a Medicare-dependent, small rural hospital (MDH). (For additional information on the MDH program and the payment methodology, we refer readers to the FY 2012 IPPS/LTCH PPS final rule (76 FR 51683 through 51684).) As discussed in section V.B. of the preamble of this final rule, the MDH program provisions at section 1886(d)(5)(G) of the Act will expire at the end of FY 2022. Beginning with discharges occurring on or after October 1, 2022, all hospitals that previously qualified for MDH status will be paid based on the Federal rate.

Since the extension of the MDH program through FY 2012 provided by section 3124 of the Affordable Care Act, the MDH program had been extended by subsequent legislation as follows: section 606 of the ATRA (Pub. L. 112–240) extended the MDH program through FY 2013 (that is, for discharges occurring before October 1, 2013). Section 1106 of the Pathway for SGR Reform Act of 2013 (Pub. L. 113–67) extended the MDH program through the first half of FY 2014 (that is, for discharges occurring before April 1, 2014). Section 106 of the PAMA (Pub. L. 113–93) extended the MDH program through the first half of FY 2015 (that is, for discharges occurring before April 1, 2015). Section 205 of the MACRA (Pub. L. 114–10) extended the MDH program through FY 2017 (that is, for discharges occurring before October 1, 2017). Section 50205 of the Bipartisan Budget Act (Pub. L. 115– 123) extended the MDH program through FY 2022 (that is for discharges occurring before October 1, 2022). For additional information on the extensions of the MDH program after FY 2012, we refer readers to the following **Federal Register** documents:

- The FY 2013 IPPS/LTCH PPS final rule (77 FR 53404 through 53405 and 53413 through 53414).
- The FY 2013 IPPS notice (78 FR 14689).
- The FY 2014 IPPS/LTCH PPS final rule (78 FR 50647 through 50649).
- The FY 2014 interim final rule with comment period (79 FR 15025 through 15027).
- The FY 2014 notice (79 FR 34446 through 34449).
- The FY 2015 IPPS/LTCH PPS final rule (79 FR 50022 through 50024).
- The August 2015 interim final rule with comment period (80 FR 49596).
- The FY 2017 IPPS/LTCH PPS final rule (81 FR 57054 through 57057).
- The FY 2018 notice (83 FR 18303 through 18305).
- The FY 2019 IPPS/LTCH PPS final rule (83 FR 41429).

2. Expiration of the MDH Program

Because section 50205 of the Bipartisan Budget Act extended the MDH program through FY 2022 only, beginning October 1, 2022, the MDH program will no longer be in effect. Because the MDH program is not authorized by statute beyond September 30, 2022, beginning October 1, 2022, all hospitals that previously qualified for MDH status under section 1886(d)(5)(G) of the Act will no longer have MDH status and will be paid based on the IPPS Federal rate.

When the MDH program was set to expire at the end of FY 2012, in the FY 2013 IPPS/LTCH PPS final rule (77 FR 53404 through 53405), we revised our sole community hospital (SCH) policies to allow MDHs to apply for SCH status in advance of the expiration of the MDH program and be paid as such under certain conditions. We codified these changes in the regulations at § 412.92(b)(2)(i) and (v). Specifically, the existing regulations at § 412.92(b)(2)(v) allow for an effective date of an approval of SCH status that is the day following the expiration date of the MDH program. We note that these same conditions apply to MDHs that intend to apply for SCH status with the expiration of the MDH program on September 30, 2022. Therefore, in order for an MDH to receive SCH status effective October 1, 2022, the MDH must apply for SCH status at least 30 days before the expiration of the MDH program; that is, the MDH must apply for SCH status by September 1, 2022. The MDH also must request that, if approved as an SCH, the SCH status be effective with the expiration of the MDH program; that is, the MDH must request that the SCH status, if approved, be effective October 1, 2022, immediately after its MDH status expires with the expiration of the MDH program on September 30, 2022. We emphasize that an MDH that applies for SCH status in anticipation of the expiration of the MDH program would not qualify for the October 1, 2022, effective date for SCH status if it does not apply by the September 1, 2022, deadline. If the MDH does not apply by the September 1, 2022, deadline, the hospital would instead be subject to the usual effective date for SCH classification; that is, as of the date the MAC receives the complete application as specified at § 412.92(b)(2)(i).

We note that the regulations governing the MDH program are found at § 412.108 and the MDH program is also cited in the general payment rules in the regulations at § 412.90. As stated earlier, under current law, the MDH program will expire at the end of FY 2022, which is already reflected in §§ 412.108 and 412.90(j). As such, we did not propose specific amendments to the regulations at § 412.108 or § 412.90 to reflect the expiration of the MDH program. However, we proposed that if the MDH program were to be extended by law, similar to how it was extended through FY 2013, by the ATRA (Pub. L. 112–240); through March 31, 2014, by the Pathway for SGR Reform Act of 2013 (Pub. L. 113–167); through March 31, 2015, by the PAMA (Pub. L. 113–93); through FY 2017, by the MACRA (Pub. L. 114–10); and most recently through FY 2022, by the Bipartisan Budget Act of 2018 (Pub. L. 115–123), we would make conforming changes to the regulations governing the MDH program at § 412.108(a)(1) and (c)(2)(iii) and the general payment rules at § 412.90(j) to reflect such an extension of the MDH program. We stated that these conforming changes would only be made if the MDH program were to be extended by statute beyond September 30, 2022. As of the time of the development of this final rule, there has been no change in law to extend the MDH program beyond FY 2022. Therefore, in this final rule, we are not making any additional changes to the regulations governing the MDH program at § 412.108 or the general payment rules at § 412.90.

Comment: Many commenters expressed support for extending the MDH program or making the MDH program permanent and noted that they would continue supporting congressional efforts to protect the MDH program. Some commenters also

expressed support for an additional base year for calculating MDH payments. A commenter urged CMS to remove the MDH program expiration proposal from the final rule. Several state hospital associations expressed their concern that hospitals in their states would experience significant payment decreases as a result of the expiration of the MDH program. A few commenters urged for action to be taken to ensure that the MDH program is extended, while other commenters urged CMS to explore alternatives and make immediate adjustments within its authority to provide relief and mitigate negative impacts to rural hospitals should Congress not act.

Response: While we appreciate the commenters' concerns about the expiration of the MDH program and the financial impact to affected providers if the MDH program is not extended beyond FY 2022, CMS does not have the authority under current law to extend the MDH program beyond the September 30, 2022 statutory expiration date. Similarly, Section 1886(b)(3)(D) of the Act specifies the applicable base years or ''target amounts'' for hospitals classified as MDHs. These comments are similar to comments we received previously, prior to the statutory extension of the MDH program for FY 2018 through FY 2022 provided by subsequent legislation, and discussed in the FY 2018 IPPS/LTCH PPS final rule (82 FR 38220 through 38221). In response to the comment urging CMS to explore other relief options should Congress not act, we will consider this for future rulemaking and explore potential ways to provide support to this subset of rural providers.

Comment: Several commenters expressed support for CMS' policy that allows MDHs to apply for SCH status in advance of the expiration of the MDH program and be paid as such under certain conditions. Some commenters also requested that CMS also provide former MDHs with the ability to rescind their newly acquired SCH status and reinstate their MDH status in a seamless manner, if a retroactive extension to the MDH program is made.

Response: We appreciate the commenters' support of our policy allowing MDHs to apply for SCH status in advance of the expiration of the MDH program and to be paid as such under certain conditions and allow for a seamless transition from MDH classification to SCH classification. In response to the suggestion that CMS provide former MDHs with ability to rescind their newly acquired SCH status and reinstate their MDH status in a seamless manner if a retroactive extension to the MDH program is made, we understand the desire on the part of hospitals for certainty in the face of MDH program expiration and will consider for future rulemaking any potential mechanisms to further streamline such transitions in connection with legislative extensions of the MDH program. We note that under the current regulations at § 412.108(b)(4), the effective date for MDH classification is as of the date the MAC receives the complete application. A MDH that applied for and was classified as an SCH in advance of the MDH expiration per the regulations at § 412.92(b)(2)(v) could request a cancellation of its SCH status and simultaneously re-apply for MDH status if the MDH program were to be extended, and the MDH classification would be effective as of the date that the MAC receives the complete application. This would allow a former MDH to maintain special payment status as an SCH and then as an MDH generally without interruption in the event the MDH program is extended.

Comment: Commenters urged CMS to expedite restoration of MDH status, should Congress act to extend these programs, stating that past retroactive restorations have seen delays that caused significant cash flow problems to affected hospitals. They requested that CMS move expeditiously to restore payments so that these rural facilities are able to continue to provide quality care to their communities and that CMS clarify how it might handle program extensions, should Congress enact legislation to extend them.

Response: We appreciate the commenters' sharing their concerns relating to a retroactive restoration of the MDH program. As with past extensions, CMS will evaluate enacted legislation to determine the most appropriate approach to implement changes to the law, including instructions to the MACs to reinstate MDH status to eligible hospitals. As in the past, we will make every effort to implement any extension of the MDH program as expeditiously as possible.

In summary, under current law, beginning October 1, 2022, all hospitals that previously qualified for MDH status will no longer have MDH status.

E. Indirect Medical Education (IME) Payment Adjustment Factor (§ 412.105)

Under the IPPS, an additional payment amount is made to hospitals with residents in an approved graduate medical education (GME) program in order to reflect the higher indirect patient care costs of teaching hospitals relative to nonteaching hospitals. The payment amount is determined by use of a statutorily specified adjustment factor. The regulations regarding the calculation of this additional payment, known as the IME adjustment, are located at § 412.105. We refer readers to the FY 2012 IPPS/LTCH PPS final rule (76 FR 51680) for a full discussion of the IME adjustment and IME adjustment factor. Section 1886(d)(5)(B)(ii)(XII) of the Act provides that, for discharges occurring during FY 2008 and fiscal years thereafter, the IME formula multiplier is 1.35.

Accordingly, for discharges occurring during FY 2023, the formula multiplier is 1.35. We estimate that application of this formula multiplier for the FY 2023 IME adjustment will result in an increase in IPPS payment of 5.5 percent for every approximately 10 percent increase in the hospital's resident-to-bed ratio.

We did not receive any comments regarding the IME adjustment factor, which, as noted earlier, is statutorily required. Accordingly, for discharges occurring during FY 2023, the IME formula multiplier is 1.35.

F. Payment for Indirect and Direct Graduate Medical Education Costs (§§ 412.105 and 413.75 Through 413.83)

1. Background

Section 1886(h) of the Act, as added by section 9202 of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 (Pub. L. 99–272) and as currently implemented in the regulations at 42 CFR 413.75 through 413.83, establishes a methodology for determining payments to hospitals for the direct costs of approved graduate medical education (GME) programs. Section 1886(h)(2) of the Act sets forth a methodology for the determination of a hospital-specific base-period per resident amount (PRA) that is calculated by dividing a hospital's allowable direct costs of GME in a base period by its number of full-time equivalent (FTE) residents in the base period. The base period is, for most hospitals, the hospital's cost reporting period beginning in FY 1984 (that is, October 1, 1983 through September 30, 1984). The base year PRA is updated annually for inflation. In general, Medicare direct GME payments are calculated by multiplying the hospital's updated PRA by the weighted number of FTE residents working in all areas of the hospital complex (and at nonprovider sites, when applicable), and the hospital's Medicare share of total inpatient days.

Section 1886(d)(5)(B) of the Act provides for a payment adjustment

known as the indirect medical education (IME) adjustment under the IPPS for hospitals that have residents in an approved GME program, in order to account for the higher indirect patient care costs of teaching hospitals relative to nonteaching hospitals. The regulations regarding the calculation of this additional payment are located at 42 CFR 412.105. The hospital's IME adjustment applied to the DRG payments is calculated based on the ratio of the hospital's number of FTE residents training in either the inpatient or outpatient departments of the IPPS hospital (and, for discharges occurring on or after October 1, 1997, at non-provider sites, when applicable) to the number of inpatient hospital beds.

The calculation of both direct GME payments and the IME payment adjustment is affected by the number of FTE residents that a hospital is allowed to count. Generally, the greater the number of FTE residents a hospital counts, the greater the amount of Medicare direct GME and IME payments the hospital will receive. In an attempt to end the implicit incentive for hospitals to increase the number of FTE residents, Congress, through the Balanced Budget Act of 1997 (Pub. L. 105–33), established a limit on the number of allopathic and osteopathic residents that a hospital could include in its FTE resident count for direct GME and IME payment purposes. Under section 1886(h)(4)(F) of the Act, for cost reporting periods beginning on or after October 1, 1997, a hospital's unweighted FTE count of residents for purposes of direct GME may not exceed the hospital's unweighted FTE count for direct GME in its most recent cost reporting period ending on or before December 31, 1996. Under section 1886(d)(5)(B)(v) of the Act, a similar limit based on the FTE count for IME during that cost reporting period is applied, effective for discharges occurring on or after October 1, 1997. Dental and podiatric residents are not included in this statutorily mandated cap.

As mentioned previously, Medicare direct GME payments are calculated by multiplying the hospital's updated PRA by the weighted number of FTE residents working in all areas of the hospital complex (and at nonprovider sites, when applicable), and the hospital's Medicare share of total inpatient days. Section 1886(h)(4) of the Act specifies the methodology for determining the amount of FTE residents to be included in a hospital's direct GME payment formula. That is, the number of FTE residents training at a hospital (or in non-provider sites as applicable) would not necessarily equal the sum of those FTE residents used in the hospital's direct GME payment formula, since certain rules and factors are applied to adjust the count of FTE residents for direct GME payment purposes. First, section 1886(h)(4)(C) of the Act requires that a ''weighting factor'' of either 1.0 or 0.5 be applied to each FTE resident, as follows: In calculating the number of FTE residents in an approved residency program on or after July 1, 1987, for a resident who is not in the resident's initial residency period, the weighting factor is 0.50. Section 1886(h)(5)(F) of the Act defines the term ''initial residency period'' as the ''period of board eligibility,'' with certain exceptions. Finally, section 1886(h)(4)(G) of the Act states that the term ''period of board eligibility'' means, for a resident, the minimum number of years of formal training necessary to satisfy the requirements for initial board eligibility in the particular specialty for which the resident is training. The direct GME calculation and our policy on applying the weighting factors to each FTE resident based on the FTE resident's status within or beyond the initial residency period (IRP) was established in the September 29, 1989, **Federal Register** (54 FR 40287, 40292, 40305 and 40306), and implemented in the regulations at 42 CFR 413.86(f) (now 42 CFR 413.79(a) and (b)).

Thus, the FTE count used in the direct GME payment formula must be a weighted FTE count when a hospital is training residents beyond their IRPs. However, the direct GME FTE cap is an unweighted number. That is, under section 1886(h)(4)(F) of the Act, for cost reporting periods beginning on or after October 1, 1997, a hospital's *unweighted* FTE count of residents for purposes of direct GME may not exceed the hospital's *unweighted* FTE count for direct GME in its most recent cost reporting period ending on or before December 31, 1996 (that is the hospital's unweighted 1996 FTE cap or FTE cap). Regulations regarding the FTE caps and unweighted FTE counts were first published in the August 29, 1997, **Federal Register** (62 FR 45966). To address situations where a hospital's weighted FTE count exceeds its unweighted 1996 FTE cap, we established a policy effective for cost reporting periods beginning on or after October 1, 1997, to bring the weighted FTE count within the unweighted FTE cap using the following ratio on the Medicare cost report: ((1996 unweighted FTE cap/current year unweighted FTE count) × (current year total weighted FTE count)) (see 62 FR 46005 and 63 FR 26,330 (May 12, 1998)). In the August 1, 2001, **Federal Register** (66 FR 39893 through 39896), we modified this ratio effective for cost reporting periods beginning on or after October 1, 2001, to separately account for a hospital's current year weighted primary care and obstetrics/gynecology (OB/GYN) FTE count and primary care and OB/GYN PRA, and current year weighted other FTE count and other PRA, as follows: (FTE cap/unweighted total FTEs in the cost reporting period) × (weighted primary care and OB/GYN FTEs in the cost reporting period) plus (FTE cap/ unweighted total FTEs in the cost reporting period) × (weighted nonprimary care FTEs in the cost reporting period). The sum of the products is the current year allowable weighted FTE count. In addition, effective for cost reporting periods beginning on or after October 1, 2001, the direct GME payment is calculated using two separate rolling averages, one for primary care and OB/GYN FTE residents, and one for nonprimary care FTE residents. These calculations were implemented at 42 CFR 413.86(g)(4) and (5) respectively, currently 42 CFR 413.79(c)(2)(iii) and (d)(3).

2. Milton S. Hershey Medical Center, et al. v. Becerra Litigation

On May 17, 2021, the U.S. District Court for the District of Columbia ruled against CMS's method of calculating direct GME payments to teaching hospitals when those hospitals' weighted FTE counts exceed their direct GME FTE cap. In *Milton S. Hershey Medical Center, et al.* v. *Becerra* (Slip. Op., 2021 WL 1966572, May 17, 2021), the court ordered CMS to recalculate reimbursement owed, holding that CMS's regulation impermissibly modified the statutory weighting factors discussed previously. The plaintiffs in these consolidated cases alleged that as far back as 2005, the proportional reduction that CMS applied to the weighted FTE count when the weighted FTE count exceeded the FTE cap conflicted with the Medicare statute, and it was an arbitrary and capricious exercise of agency discretion under the Administrative Procedure Act. The Court held that the proportional reduction methodology improperly modified the weighting factors statutorily assigned to residents and fellows. The court ordered CMS to pay the plaintiffs according to a more favorable method.

For example, a hospital has a direct GME cap of 100, trains 90 FTE residents weighted at 1.0 and 10 FTE fellows weighted at 0.5, for a total unweighted

count of 100, and a total weighted FTE count of 95. Under current methodology, the proportional reduction is: (100 cap/100 current year unweighted count) × 95 (current year weighted count) = 95.

If that hospital adds 10 more fellows and exceeds the cap with an unweighted total of 110 (90 residents and 20 fellows), its weighted FTE count of 100 is reduced as follows: (100 cap/110 current year unweighted count) × 100 (current year weighted count) = 90.91.

The plaintiffs stated that CMS's proportional reduction method unlawfully reduced the weighting factor of 0.5 to an amount less than that, thereby reducing the capped weighted FTE amount (100 reduced to 90.91 in the example) to which they were entitled for direct GME payment purposes. The court granted the plaintiffs' motion for summary judgment, denied defendant's, and remanded to the Agency so that it could recalculate plaintiffs' reimbursement payments consistent with the court's opinion. The court held that CMS's proportional reduction methodology, enacted at 42 CFR 413.79(c)(2)(iii), was inconsistent with the statutory weighting factors. In response to the court's decision, in the FY 2023 IPPS/LTCH PPS proposed rule (87 FR 28410 through 28412), we proposed to implement a modified policy applicable to all teaching hospitals, effective as of October 1, 2001, which would replace the existing policy at 42 CFR 413.79(c)(2)(iii). While the proportional reduction method struck down in *Hershey* was first effective for cost reports beginning on or after October 1, 1997, we are unaware of any open or reopenable NPRs for the 1997–2001 period where the proportional reduction method caused a provider's payments to be lower than they would be under our proposed new policy, but we welcomed comments alerting us of such NPRs. The proportional reduction method was amended to its present form effective for cost reporting periods beginning on or after October 2001. (*See* current 42 CFR 413.79(c)(2)(ii) and (iii).) Therefore, we proposed to modify the policy embodied in 42 CFR 413.79(c)(2)(iii), which the Court found in *Hershey* was inconsistent with the statute.

The Court's decision in *Hershey* held that our prior rule governing ''computation of the approved number of full-time equivalent residents in an approved medical residency training program'' (§ 1886(h)(4) of the Act) was inconsistent with the statute. That statute further requires us to ''establish rules consistent with this paragraph'' for the computation of FTEs. Following our review of the district court's reasoning in *Hershey* and the statute, we concluded that our existing formula for computing the number of FTEs was inconsistent with the statutory requirements. It is also our view that the combination of the statutory requirement to ''establish rules'' and the *Hershey* court's conclusion that our existing rules are inconsistent with statutory requirements necessitates a new rulemaking. We further note that the *Hershey* decision does not mandate an alternative payment method, and we do not believe that the decision—or our independent conclusion that the formula should be modified—forecloses alternatives to the calculation method we finalize here. In the FY 2023 IPPS/LTCH PPS proposed rule (87 FR 28411), we stated our belief that, in order to comply with the statutory requirement to make rules governing the computation of FTEs, it is necessary to engage in a retroactive rulemaking to modify the statutorily-required rule effective for cost reporting periods beginning on or after October 1, 2001. While *Hershey* itself does not mandate this conclusion, we believe it would be inconsistent with the statute to calculate past payments for open cost reports based on a rule inconsistent with the law, particularly where a court ordered us to recalculate payments to plaintiffs. Doing so via notice-and-comment rulemaking is in the public interest because it will permit interested stakeholders to comment on the proposed approach, allow the agency to have the benefit of those comments in the development of a final rule, and calculate payments for past open cost years in a transparent, consistent, and efficient manner. This is particularly true in this situation, where the existing policy was promulgated via an interim final rule with comment period, and the agency received no comments on the policy the court found unlawful.

In the proposed rule, we noted that because we proposed to establish this policy retroactively, it would cover cost reporting periods for which many NPRs have already been settled. Consistent with § 405.1885(c)(2), any final rule retroactively adopting the proposed new policy would not be the basis for reopening final settled NPRs.

After reviewing the statutory language regarding the direct GME FTE cap and the court's reasoning, we decided to propose a modified policy to be applied for cost reporting periods beginning on October 1, 2001, as described previously. The proposed modified policy would address situations for applying the FTE cap when a hospital's weighted FTE count was greater than its FTE cap, but would not reduce the weighting factor of residents that are beyond their IRP by an amount less than 0.5. Section 1886(h)(4)(F) of the Act states that for purposes of a cost reporting period beginning on or after October 1, 1997, the total number of FTE residents before application of weighting factors may not exceed the number of such FTEs for the hospital's most recent cost reporting period ending on or before December 31, 1996. Under current policy, we interpreted this to mean that only a hospital's unweighted (before application of weighting factors) allopathic and osteopathic FTE count was compared to its FTE cap, and if the unweighted allopathic and osteopathic FTE count exceeded the FTE cap, then the proportional reduction is made to the weighted FTE counts. Under this modified proposed policy, in the instance where a hospital's unweighted allopathic and osteopathic FTE count exceeds its FTE cap, we proposed to add a step to also compare the total *weighted* allopathic and osteopathic FTE count to the FTE cap. If the total weighted allopathic and osteopathic FTE count is equal to or less than the FTE cap, then no adjustments would be made to the respective primary care & OB/GYN weighted FTE counts or the other weighted FTE counts. If the total weighted allopathic and osteopathic FTE count exceeds the FTE cap, then we would adjust the respective primary care & OB/GYN weighted FTE counts or the other weighted FTE counts to make the total weighted FTE count *equal* the FTE cap, as follows:

((primary care & OB/GYN weighted FTEs/total weighted FTEs) × FTE cap)) + ((other weighted FTEs/total weighted FTEs) × FTE cap)).

The sum would be the current year total allowable weighted FTE count, which would be reported on Worksheet E–4, line 9, column 3.

More specific to the Medicare cost report, we proposed to revise the instructions to Worksheet E–4, line 9 to state: If line 6 is less than or equal to line 5, enter the amounts from line 8, columns 1 and 2, in columns 1 and 2, of this line. Otherwise, *if the total weighted FTE count from line 8, column 3 is greater than the amount on line 5, then enter in column 1 the result of ((primary care & OBGYN weighted FTEs/total weighted FTEs) × FTE cap)). Enter in column 2 the result of ((other weighted FTEs/total weighted FTEs) × FTE cap)). Enter in column 3 the sum of*

((primary care & OBGYN weighted FTEs/total weighted FTEs) × FTE

cap)) + ((other weighted FTEs/total weighted FTEs) × FTE cap)).

Example : [Note—see the comments and responses later in this section for a revised version of this Example 1] Hospital with an FTE cap of 100 trains 120 FTEs with a weight of 1.0, and 105 FTEs with a weight of 0.5, consisting of 70 weighted primary care & OBGYN FTEs and 35 weighted other FTEs. Since the total weighted count of 105 (Worksheet E–4, line 8, column 3) exceeds the FTE cap of 100 (Worksheet E–4, line 5), the Hospital reports the following adjusted weighted FTE counts on Worksheet E–4:

Line 9, column 1: ((70 weighted primary care & OBGYN FTEs/105 total weighted FTEs) × 100 cap)) = 66.67.

Line 9, column 2: ((35 weighted other FTEs/105 total weighted FTEs) × 100 cap)) = 33.33.

Line 9, column 3: 66.67 FTEs + 33.33 FTEs = 100.

Example 2: Hospital with an FTE cap of 100 trains 102 unweighted FTEs, equating to 96 weighted FTEs. This 96-weighted count consists of 30 weighted primary care & OBGYN FTEs, and 66 weighted other FTEs. Since the total weighted count of 96 (Worksheet E–4, line 8, column 3) is less than the FTE cap of 100 (Worksheet E–4, line 5), then no further adjustment is needed; enter the amounts from line 8, columns 1 and 2, in columns 1 and 2, of line 9.

Example 3: Hospital with a cap of 100 FTEs trains 90 FTEs with a weight of 1.0, and 20 FTEs with a weight of 0.5. Since the total weighted count is 100 (90 + (20 × 0.5)), then no further adjustment is needed. Enter the amounts from line 8, columns 1 and 2, in columns 1 and 2 of line 9.

Comment: We received many comments supporting our proposed revision to the weighted count methodology and to the Medicare cost reporting instructions. Commenters urged CMS to finalize the proposed revision, asserting it is required by the law and the court's order, and to recalculate payments immediately, as over a year has passed since the court order.

Response: We appreciate the commenters' support, and upon issuance of this final rule, we will work with the MACs and other impacted parties to recalculate and issue adjusted payments as soon as possible.

Comment: Many commenters urged CMS to abandon the proposal to use retroactive rulemaking as the means of complying with the decision of the Hershey court. These commenters stated that retroactive rulemaking is strongly disfavored under the Medicare statute and permitted only under limited circumstances as specified in section 1871(e)(1)(A) of the Act, namely, when it is either necessary to comply with statutory requirements (§ 1871(e)(1)(A)(i)) of the Act); or when failure to apply the change retroactively would be contrary to the public interest (§ 1871(e)(1)(A)(ii) of the Act). Commenters asserted that neither of these exceptions applies in the present case.

With respect to the exception at section 1871(e)(1)(A)(i) of the Act, commenters stated that retroactive rulemaking is not necessary for CMS to comply with statutory requirements. Commenters said that the Medicare statute is unambiguous with respect to the weighting of residents and fellows, and that the proposed revision to the methodology is the only way for CMS to comply with the statutory directive and the Hershey decision, neither of which requires any interpretation by the agency. Commenters also stated that the exception at section 1871(e)(1)(A)(ii) does not apply, since it does not serve the public interest for CMS to engage in retroactive rulemaking and to entertain public comments on actions that the agency is required to take under a legally binding court order. According to a commenter, engaging in retroactive rulemaking in this instance implicitly contradicts the court's decision, while others expressed concern that it would create a precedent whereby CMS might invoke public interest in receiving comments as a justification for virtually any retroactive rule change. Commenters also stated that it is not necessary for CMS to engage in retroactive rulemaking to benefit from public comments, pointing out that in the past the agency has made retroactive policy changes via program instruction and only submitted the policies to public comment for purposes of prospective application.

Commenters also rejected the argument that retroactive rulemaking in this instance is necessary to comply with the Supreme Court's ruling in *Azar* v. *Allina Health Services.* Commenters observed that the Allina ruling established the need for notice-and-comment rulemaking to change a substantive legal standard governing payment where the agency engages in ''gap-filling'' an ambiguous statute. However, as previously stated, commenters believed that the statute is unambiguous with regard to the weighting of residents and fellows, and that therefore there are no gaps for the agency to fill. In other words, as stated by a commenter, the proposed policy is already dictated by the statute as explained in Hershey, and there is no room for CMS to substantively change the policy enacted by Congress.

Furthermore, commenters disagreed with CMS's position, as originally stated in the FY 2023 IPPS/LTCH proposed rule, that retroactive rulemaking is necessary in the wake of the Hershey ruling since the Secretary ''has no promulgated rule governing'' direct GME payments to teaching hospitals over the cap for cost reporting periods beginning on or after October 1, 2001 (87 FR 28411). A number of commenters stated that the Hershey court did not leave CMS with a regulatory void to fill, but merely ruled ''that the regulation is unlawful as applied to the Plaintiffs''; even if the court had vacated the existing regulation, these commenters asserted that notice-and-comment rulemaking would not be required or appropriate to acquiesce to the vacatur. By contrast, another commenter stated that the existing regulation is a ''legal nullity'' in light of the Hershey decision, but nevertheless stated that the statutory payment directive requires no substantive change in policy and can be properly effectuated without rulemaking.

Citing a number of examples, commenters observed that historically, both before and after Allina, CMS has implemented policy changes to resolve appeals or comply with court decisions without engaging in retroactive rulemaking, and invoked its retroactive rulemaking authority only under particular circumstances, such as in response to a natural disaster or when a rule is published after a statute's effective date. Only more recently, according to commenters, has CMS inappropriately begun to engage in retroactive rulemaking in response to litigation. Rather than engage in retroactive rulemaking to comply with the Hershey decision, commenters urged CMS to make the change in regulation prospectively and to employ other appropriate means, such as program instruction to the MACs or settlement with hospitals, to implement the proposed correction for past years.

While urging CMS to abandon retroactive rulemaking as the means of complying with the Hershey decision, commenters stated that, if CMS does engage in retroactive rulemaking, it should specify exactly which hospitals and past cost reporting periods will be eligible for relief under the revised policy. In particular, commenters pointed out that CMS proposed that ''certain other providers'' will be eligible for relief in addition to the plaintiffs in Hershey, but the preamble does not make it clear who those

providers will be. These commenters stated that CMS should reopen all cost reports within the three-year reopening period and recalculate direct GME payments consistent with the statute. At a minimum, however, the ''certain other providers'' should include any provider that, if applicable, has an appeal pending with the Provider Reimbursement Review Board or in federal court on the same issue as Hershey. In addition, if CMS does not reopen all cost reports that are within the three-year reopening period, it should nonetheless apply the methodology any time a cost report is reopened and the direct GME payment is altered. Other commenters likewise stated that hospitals should be permitted to reopen their cost reports for the purpose of recalculating their direct GME payments according to the revised weighting methodology, and that CMS should not finalize any ongoing cost report audits until the final rule has been issued.

Some commenters expressed concern that CMS's proposal to extend relief to only certain providers is inconsistent with concept of retroactive rulemaking. Another commenter objected to CMS's statement that under 42 CFR 405.1885(c)(2), any final rule retroactively adopting the proposed new policy would not be the basis for reopening final settled NPRs (87 FR 28411). This commenter asserted that § 405.1885(c)(2) does not apply to retroactive rulemaking, and that CMS's proposal has ''no real retroactive effect'' if it does not serve as the basis for reopening settled cost reports. Another commenter similarly recommended that CMS make the new policy ''fully retroactive'' so that even final settled NPRs subject to reopening may be reopened for the purpose of applying the revised methodology. This commenter stated that withholding relief from certain providers would be arbitrary and capricious and result in CMS not fully complying with the statute.

Response: We appreciate the comments regarding our proposal to implement the court's decision in *Hershey* retroactively, but for the reasons that follow (as well as those stated in the proposed rule), we are finalizing our policy as proposed, retroactive to 2001.

We agree with commenters who objected to our statement that there is ''no promulgated rule governing'' direct GME payments to over-the-cap hospitals. The *Hershey* court did not vacate the rule. We further agree that the *Hershey* decision itself does not require us to engage in retroactive rulemaking. However, the statute at issue states that ''[t]he Secretary shall establish rules *consistent with this paragraph* for the computation of the number of full-time equivalent residents in an approved medical residency training program.'' Section1886(h)(4)(A) of the Act (emphasis added). And the *Hershey* court did say that the rules at issue were not consistent with the statute. Following our review of the *Hershey* court's reasoning and the statutory requirements, we decided that our method for computing FTEs was not consistent with statutory requirements. We therefore conclude that our existing rule, which does not comply with the statute, should be modified retroactively such that our FTE computation rules are consistent with the statute and payments, including payments for open cost years in past, are calculated pursuant to regulation.

Several commenters state that no rule is necessary because of an express statutory mandate that fellows be counted as 0.5 FTE. We disagree, for two reasons. First, there are two express statutory mandates in the section cited by commenters: that the Secretary promulgate rules, and that those rules weight fellows at 0.5 FTE (see sections 1886(h)(4)(A) and 1886(h)(4)(C)(iv) of the Act). In other words, the statutory language cited by commenters describes the content of the rules the Secretary is required to promulgate, rather than setting an independent statutory benchmark. Second, we disagree with the commenters' position that the rule we proposed was the only possible way to compute FTE counts in light of *Hershey.* Section 1886(h)(4)(C) is not the only relevant statutory provision governing the content of the rule; section 1886(h)(4)(F)(i) of the Act requires the rules to cap the number of unweighted residents based on a hospital's FY 1996 FTE count. In *Hershey* itself, the court did not mandate a particular method of calculation or require CMS to adopt the plaintiffs' proposed calculation method. We believe that there is more than one way to comply with the statutory requirements and the court's order. Our decision in this rule does not mean that all other alternatives were foreclosed by the *Hershey* decision. The *Hershey* court decision held that the prior regulation governing FTE counting for over-the-cap hospitals was unlawful. It did not mandate any particular alternative approach. We further disagree with commenters to the extent they suggest that we compute FTE counts without a rule in place for doing so. As discussed elsewhere, the statute at issue requires the Secretary to establish a rule.

Even if the *Hershey* decision did mandate a single method of computing FTE counts, it was silent on how to incorporate that computation into the three-year rolling average. Without a rule for determining the inputs to the three-year-rolling average, which we proposed and are now finalizing, it is impossible to calculate a given provider's dollar reimbursement. Therefore, even if we agreed with commenters that the *Hershey* decision provided sufficient guidance for computing FTE counts and that no further rulemaking on that issue is required, we would nonetheless consider it necessary to undergo rulemaking to implement our response to the decision, that is, use its requirements to develop a method for calculating reimbursement. For these reasons, we disagree with commenters who believe that notice-and-comment rulemaking is unnecessary to implement the Hershey decision, including for past cost years.

We appreciate the comments about retroactive rulemaking here being inconsistent with CMS's historical practice. Many of the examples raised by commenters do not involve judicial decisions calling into question agency rules, which is a key factor here, as we noted in the proposed rule. The governing statute requires the Secretary to promulgate rules governing reimbursement that are consistent with statutory requirements, and the court's decision in *Hershey* concluded that our existing rule was not consistent with those requirements. We do not believe that using retroactive rulemaking in this instance is inconsistent with our past practice.

We acknowledge that our statutory authority to engage in retroactive rulemaking is limited by section 1871(e)(1)(A) of the Act. As previously discussed, we believe that the explicit statutory requirement that the Secretary promulgate a rule governing GME reimbursement renders retroactive application here ''necessary to comply with statutory requirements.'' 1871(e)(1)(A)(i). If we promulgated this rule prospectively only, a necessary result would be that some hospitals would receive GME reimbursement based on a computation of FTE equivalents that was not established by rule. We emphasize again that the rule at issue in *Hershey* and the rule we promulgate here are not merely statutory gap-fillers. The statute affirmatively requires us to promulgate a rule.

In the alternative, and even if it were permissible to compute the number of FTEs without a rule governing the methodology for doing so, we believe that retroactive rulemaking here is in the public interest (section 1871(e)(1)(A)(ii) of the Act). In response to comments, we want to make clear that we believe that public notice-and-comment will benefit the rulemaking process generally. As we noted in the preamble, there was limited public comment on the key provisions of the original rulemaking that the *Hershey* court found inconsistent with statutory requirements. And we acknowledge—and we do not believe that commenters disagree—that it is necessary to recalculate past payments in light of the Hershey decision. The public interest will be served by having past payments calculated in the same way as future payments, and given our view that it is necessary to engage in notice-and-comment rulemaking to implement the Hershey decision, we believe it is sensible and efficient to calculate past payments based on a formula promulgated with the benefit of notice-and-comment rulemaking. We do not mean to imply that the public interest requires consistency between past payments and future payments in all conceivable situations. However, where—as here— payment was set by a regulation that a court held inconsistent with substantive statutory requirements and the agency engages in new notice-and-comment rulemaking to implement that judicial ruling, there is a public benefit in having past payments calculated via the same method as future payments. This is particularly true where the statute at issue requires that payments be calculated pursuant to a rule. We therefore believe that this is a case where the public interest in having a rule applicable to all payments, both past and future, justifies retroactive rulemaking. It would be contrary to the public interest for plaintiffs in *Hershey* and other judicial challenges to have their payments calculated by a different methodology (whether more or less generous than the methodology established by regulation) than other providers that are otherwise similarly situated. Retroactive rulemaking in this situation, benefits the public interest by achieving parity in payment among similarly situated hospitals.

We also believe that the public interest is served by having payments for past open cost years calculated in a transparent, efficient, and not administratively burdensome fashion, an interest that is served by promulgating a rule (following notice-and-comment) that applies to those cost years. This rule will allow us to calculate payments to hospitals with open cost reports based on a universal and transparent formula, and it will allow many hospitals (and MACs) to avoid the administrative expense of calculating payments based on a formula that the agency has concluded should not be applied. The public interest is further served by reducing the need for hospitals to file administrative appeals in order to obtain the benefit of the new payment formula.

We appreciate comments regarding the applicability of 42 CFR 405.1885(c)(2) to this rule. We disagree that 405.1885(c)(2) does not apply to retroactive rules. The text of the regulation does not support that proposed carve-out. The rule we proposed—and finalize here—is a ''change of legal interpretation or policy by CMS in a regulation . . . made in response to judicial precedent,'' and thus it is ''not a basis for reopening a CMS or contractor determination.'' Some commenters urged us to apply 42 CFR 405.1885(c)(1) to direct contractors to reopen cost reports, but we note that paragraph (c)(1) allows CMS to do so (''CMS may direct a contractor . . . to reopen and revise'') subject to the prohibited reopening's in paragraph (c)(2). We disagree that this rule will have no ''real retroactive effect,'' as a number of hospitals will receive increased reimbursement for past cost reporting years.

We further disagree that it is arbitrary and capricious to apply 405.1885(c)(2) here. This is not the first time that we have made a policy change that could potentially affect closed cost reports, and we have previously declined to direct reopening of closed cost reports consistent with the policy favoring finality embedded in 405.1885(c)(2). For example, we permitted qualifying hospitals to request application of a policy change made in the FY 2020 IPPS rule to FYs 2011 through 2017, ''subject to the reopening rules at 42 CFR 405.1885.'' (84 FR 42349) We believe that the policy we finalize here is consistent with our past practice and our general approach toward finality.

Comment: Many commenters appreciated that CMS proposed that ''If the number of FTE residents weighted in accordance with paragraph (b) of this section does not exceed [the FTE cap], then the allowable weighted FTE count is the actual weighted FTE count.'' However, some commenters pointed out that CMS's proposed change to the instructions for line 9 of Worksheet E–4 does not contain language reflecting this scenario and requested that CMS add a third sentence to the proposed changes to the instructions for line 9. The sentence should state as follows: ''If the total weighted FTE count from line 8, column 3 is less than or equal to the amount on line 5, then enter the amounts from line 8, columns 1 and 2, in columns 1 and 2 of this line.''

Response: We agree with the commenters' request and will revise the proposed instructions to Worksheet E–4, line 9 to address the commenters' request. However, since we are adding the sentence requested by the commenters, then we are removing the following: ''*If line 6 is less than or equal to line 5, enter the amounts from line 8, columns 1 and 2, in columns 1 and 2, of this line.*'' This latter sentence is not necessary, since if line 6 is less than or equal to line 5, then by default line 8, column 3 will also be less than or equal to line 5. We are revising the instructions to Worksheet E–4, line 9 to state: *If the total weighted FTE count from line 8, column 3 is less than or equal to the amount on line 5, then enter the amounts from line 8, columns 1 and 2, in columns 1 and 2 of this line (emphasis added). Otherwise, if the total weighted FTE count from line 8, column 3 is greater than the amount on line 5, then enter in column 1 the result of ((primary care & OBGYN weighted FTEs/total weighted FTEs) × FTE cap)). Enter in column 2 the result of ((other weighted FTEs/total weighted FTEs) × FTE cap)). Enter in column 3 the sum of columns 1 and 2.*

Under section 1886(h)(4)(G)(i) and 42 CFR 413.79(d)(3), a hospital's weighted FTE count for payment purposes is the 3-year average of its current year weighted FTEs, prior year weighted FTEs, and penultimate year FTEs (for primary care & OBGYN FTEs and other FTEs respectively). Effective for cost reporting periods beginning on or after October 1, 2001, we proposed to implement this modified methodology for the purpose of determining the prior year weighted FTE count on line 12 of Worksheet E–4, and for the purpose of determining the penultimate year's weighted FTE count on line 13 of Worksheet E–4, even though the prior and penultimate years' FTE counts would be from cost reporting periods prior to October 1, 2001. In this manner, the modified methodology would be fully applied to determining the direct GME payment for cost reporting periods beginning on or after October 1, 2001.

Therefore, we proposed to modify the cost report instructions on Worksheet E–4, lines 12 and 13, respectively to state that effective for cost reporting periods beginning on or after October 1, 2001, if subject to the cap in the prior

year or penultimate year respectively, *if the prior/penultimate year total weighted FTE count from line 8, column 3 is greater than the amount on line 5 from the prior/penultimate year, then enter in column 1 the result of ((primary care & OBGYN weighted FTEs/total weighted FTEs) × FTE cap)). Enter in column 2 the result of ((other weighted FTEs/total weighted FTEs) × FTE cap)) plus the amount on line 10, column 2.* These instructions do not in any way modify or reopen final-settled prior and penultimate year NPRs.

Comment: Some commenters supported CMS's proposal to update the cost report instructions for lines 12 and 13 of Worksheet E–4 to ensure that the weighted resident FTE counts from the prior and penultimate years will be updated to reflect the new direct GME payment formula. However, the commenters pointed out that the proposed language for lines 12 and 13 does not specify how to calculate the weighted FTE count for the prior and/or penultimate years when the unweighted FTE count from those years exceeds the FTE cap, but the weighted FTE count from those years does not, and requested that CMS add a sentence to the instructions for lines 12 and 13 stating: ''If the prior/penultimate year total weighted FTE count from line 8, column 3 is less than or equal to line 5 from the prior/penultimate year, then enter the amounts from line 8, columns 1 and 2, in columns 1 and 2 of this line.''

Response: We agree with the commenters' request and are revising the instructions on Worksheet E–4 lines 12 and 13 to state: *Effective for cost reporting periods beginning on or after October 1, 2001, if the prior/penultimate year total weighted FTE count from line 8, column 3 is less than or equal to line 5 from the prior/penultimate year, then enter the amounts from line 8, columns 1 and 2, in columns 1 and 2 of this line (emphasis added). If subject to the cap in the prior year or penultimate year respectively, if the prior/penultimate year total weighted FTE count from line 8, column 3 is greater than the amount on line 5 from the prior/penultimate year, then enter in column 1 the result of ((primary care & OBGYN weighted FTEs/total weighted FTEs) × FTE cap)). Enter in column 2 the result of ((other weighted FTEs/total weighted FTEs) × FTE cap)) plus the amount on line 10, column 2.*

Comment: Several commenters observed that CMS should have also proposed to apply the revised direct GME weighting methodology to the so-called ''section 422 MMA (Medicare Modernization Act) cap slots'' as well. Specifically, many teaching hospitals received additional FTE caps following a redistribution of unused FTE cap slots mandated by section 422 of the MMA. Similar to the fellowship penalty, CMS applies a proportional methodology when determining payment for section 422 cap FTEs. The commenters suggested that CMS calculate the ''Section 422 Allowable Direct GME FTE Resident Count'' on Worksheet E–4, line 22 as follows:

- If the weighted FTEs on line 8 are less than or equal to the adjusted FTE cap on line 5, the hospital would have entered the weighted FTEs from line 8 on line 9. In this instance, the additional section 422 cap slots are unnecessary, and the hospital would enter zero on line 22.
- If the weighted FTEs on line 8 are greater than the adjusted FTE cap on line 5, the hospital would have entered the adjusted FTE cap on line 9. In this instance, the hospital would subtract line 9 from line 8 and proceed as follows:
  - If line 9 minus line 8 equals or exceeds the ''Section 422 Direct GME FTE Cap'' on line 20, then the hospital would enter the amount from line 20 on line 22.
  - If line 9 minus line 8 is less than line 20, the hospital would enter line 9 minus line 8 on line 20.

Response: We agree with the commenters' observation that the revised methodology should apply to the MMA section 422 FTE cap, as the mathematical cap concept is the same for the 422 FTE cap as it is for the regular FTE cap. Accordingly, for portions of cost reporting periods beginning on or after July 1, 2005, the effective date of section 422 under 42 CFR 413.79(c)(4), we will revise Worksheet E–4, line 22, as follows:

For portions of cost reporting periods beginning on or after July 1, 2005, if the weighted FTE count on line 8 is less than or equal to the adjusted FTE cap on line 5, the hospital would have entered the weighted FTEs from line 8 on line 9. In this instance, the additional § 422 cap slots are unnecessary; do not complete lines 22 through 24. If the weighted FTE count on line 8 is greater than the adjusted FTE cap on line 5, the hospital would have entered the adjusted FTE cap on line 9. In this instance, subtract line 9 from line 8. If line 9 minus line 8 equals or exceeds the ''Section 422 Direct GME FTE Cap'' on line 20, then enter the amount from line 20 on line 22. If line 9 minus line 8 is less than line 20, enter line 9 minus line 8 on line 22. (We note the commenters indicated ''enter line 9 minus line 8 on line 20,'' but we believe they meant to say ''on line 22'').

We proposed to amend the regulations text at 42 CFR 413.79(c)(2)(iii) to state that, effective for cost reporting periods beginning on or after October 1, 2001, if the hospital's unweighted number of FTE residents exceeds the limit described in this section of the final rule, and the number of weighted FTE residents in accordance with § 413.79(b) also exceeds that limit, the respective primary care and obstetrics and gynecology weighted FTE counts and other weighted FTE counts are adjusted to make the total weighted FTE count equal the limit. If the number of FTE residents weighted in accordance with § 413.79(b) does not exceed that limit, then the allowable weighted FTE count is the actual weighted FTE count.

Comment: A commenter requested that CMS make conforming changes to the three-year rolling average regulation at. § 413.79(d)(3) to clarify that the weighted FTE counts for the ''preceding two cost reporting periods'' must be calculated in accordance with the revised payment formula at § 413.79(c)(2)(iii).

Response: We agree to add a parenthetical to the regulations at § 413.79(d)(3) to state, ''For cost reporting periods beginning on or after October 1, 2001, the hospital's weighted FTE counts for the preceding two cost reporting periods are calculated in accordance with the payment formula at 42 CFR 413.79(c)(2)(iii)).''

Comment: A commenter stated they would like to see the three-year rolling average eliminated retroactive to October 1, 2001, as it would delay implementation of CMS's proposed payment formula.

Response: Under section 1886(h)(4)(G)(i) and 42 CFR 413.79(d)(3), a hospital's weighted FTE count for payment purposes is the 3-year average of its current year weighted FTEs, prior year weighted FTEs, and penultimate year weighted FTEs (for primary care & OBGYN FTEs and other FTEs respectively). Our proposed interpretation of section 1886(h)(4)(F) of the Act regarding application of weighting factors does not change this portion of the statute regarding application of the 3-year rolling average. Therefore, we are not adopting the commenter's request to eliminate application of the rolling average under our proposed payment formula.

Comment: Some commenters requested that CMS correct or clarify certain misstatements in the FY 2023 IPPS/LTCH PPS proposed rule regarding the *Hershey* case. First, CMS should be clearer about the position of the *Hershey*