Code 4120-01-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 433, 447, 455, and 457

[CMS-2445-F]

RIN 0938-AV00

Medicaid Program; Disproportionate Share Hospital Third-Party Payer Rule

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

ACTION: Final rule.

SUMMARY: This final rule primarily addresses recent legislative changes to the Social Security Act as a result of the Consolidated Appropriations Act, 2021 changes to the hospital-specific limit on Medicaid disproportionate share hospital (DSH) payments. This final rule affords States and hospitals more clarity on how the limit, the changes that took effect on October 1, 2021, will be calculated. Additionally, this final rule enhances administrative efficiency by making technical changes and clarifications to the DSH program.

DATES: *Effective date*: These regulations are effective on [INSERT DATE 60 DAYS AFTER DATE OF PUBLICATION IN THE **FEDERAL REGISTER**].

Applicability date: Sections 447.295(b) and (d), 447.299(c)(6), (7), (10), and (16), and 455.304(d)(1), (3), (4), and (6)) are applicable as of October 1, 2021 (see section III. of this final rule for additional information).

FOR FURTHER INFORMATION CONTACT: Lia Adams, (410) 786-8258, Charlie Arnold, (404) 562-7425, Richard Cuno, (410) 786-1111, Stuart Goldstein, (410) 786-0694, Charles Hines, (410) 786-0252, and Mark Wong, (415) 744-3561, for Medicaid Disproportionate Share Hospital Payments and Overpayments.

Jennifer Clark, (410) 786-2013, for Children's Health Insurance Program (CHIP).

SUPPLEMENTARY INFORMATION:

I. Background

A. Overview

Title XIX of the Social Security Act (the Act) established the Medicaid program as a Federal-State partnership for the purpose of providing and financing medical assistance to specified groups of eligible individuals. States have considerable flexibility in designing their programs but must abide by requirements specified in the Federal Medicaid statute and regulations. Each State is responsible for administering its Medicaid program in accordance with an approved State plan, which specifies the scope of covered services, groups of eligible individuals, payment methodologies, and all other information necessary to assure the State plan describes a comprehensive and sound structure for operating the Medicaid program, and ultimately, provides a clear basis for claiming Federal matching funds.

Section 1902(a)(13)(A)(iv) of the Act requires that States consider the situation of hospitals that serve a disproportionate share of low-income patients with special needs, in a manner consistent with section 1923 of Act, in determining payments. The purpose of the proposed rule[1] and this final rule is to update the regulatory requirements of the disproportionate share hospital (DSH) program in response to the Consolidated Appropriations Act, 2021 (herein, referred to as the CAA 2021) (Pub. L. 116-260, December 27, 2020) and to further improve upon the program. More specifically, the provisions of this final rule seek to implement the DSH-related provisions of the CAA 2021 concerning the treatment of third-party payments for purposes of calculating Medicaid hospital-specific DSH limits. We note that the CAA 2021 also created new supplemental payment reporting requirements through the addition of section

[1] 88 FR 11865.

1903(bb) of the Act; however, DSH payments were specifically excluded from these requirements, and we have issued guidance on those requirements.[2]

This final rule also revises regulatory payment and financing definitions and other regulatory language that could be subject to misinterpretation, refines administrative procedures used by States to comply with Federal regulations, and removes regulatory requirements that have been difficult to administer and do not further the program's objectives.

We are finalizing all provisions as proposed, although we note that the regulations have some minor phrasing changes for consistency with current style guidelines. For the CAA 2021-related provisions of this final rule, we are finalizing an applicability date of October 1, 2021, to align with the effective date in the statute. This information is noted in each of the CAA 2021-related provision sections and discussed in section III. of this final rule. The remaining provisions of this final rule are effective 60 days after publication of the final rule.

B. Disproportionate Share Hospital (DSH) Payments

1. Background

States are statutorily required to make DSH payments to qualifying hospitals that serve patients who are uninsured and enrolled in the Medicaid program, as described in section 1923(d) of the Act. States generally have flexibility regarding the specific hospitals to which they make payments and how they determine the amount of those payments, within certain parameters. Section 1902(a)(13)(A)(iv) of the Act requires that States consider the situation of hospitals that serve a disproportionate number of low-income patients with special needs, in a manner consistent with section 1923 of the Act. DSH payments are not considered part of base payments or supplemental payments to providers, as they are made under distinct statutory authority. Section 1923 of the Act contains specific requirements related to DSH payments, including aggregate annual State-specific DSH allotments that limit Federal financial

[2] "New Supplemental Payment Reporting and Medicaid Disproportionate Share Hospital Requirements under the Consolidated Appropriations Act, 2021," State Medicaid Director Letter #21-006, December 10, 2021. Available at *https://www.medicaid.gov/federal-policy-guidance/downloads/smd21006.pdf*.

participation (FFP) for Statewide total DSH payments under section 1923(f) of the Act, and hospital-specific limits on DSH payments under section 1923(g) of the Act. Under the statutory hospital-specific limits, a hospital's DSH payments may not exceed the costs incurred by that hospital in furnishing inpatient and outpatient hospital services during the year to certain Medicaid beneficiaries and the uninsured, less payments received under title XIX (other than section 1923 of the Act) and payments by uninsured patients. In addition, section 1923(a)(2)(D) of the Act requires States to provide an annual report to the Secretary describing the DSH payment adjustments made to each DSH.

Section 1001(d) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108-173, December 8, 2003) added section 1923(j) of the Act to require States to report additional information about their DSH programs. Section 1923(j)(1) of the Act requires States to submit an annual report including an identification of each hospital that received a DSH payment adjustment during the preceding fiscal year (FY) and the amount of such adjustment, and such other information as the Secretary determines necessary to ensure the appropriateness of the DSH payment adjustments for such FY. Additionally, section 1923(j)(2) of the Act requires States to submit an independent certified audit of the State's DSH program, including specified content, annually to the Secretary.

2. Consolidated Appropriations Act, 2021 (CAA 2021) DSH Requirements

The CAA 2021 was enacted on December 27, 2020. It modified the Medicaid statute in several ways, including by updating section 1923 of the Act. Specifically, Division CC, Title II, section 203 of the CAA 2021 (herein referred to as section 203) amended section 1923(g) of the Act, which describes the methodology for calculating hospital-specific Medicaid DSH limits. This provision took effect October 1, 2021. For purposes of calculating the hospital-specific DSH limit, section 203 of the CAA 2021 modified the calculation of the Medicaid portion of the hospital-specific DSH limit to include only costs and payments for services furnished to beneficiaries for whom Medicaid is the primary payer for such services, as specified in section

1923(g)(1)(B)(i) of the Act. Accordingly, the limit excludes costs and payments for services provided to Medicaid beneficiaries with other sources of coverage, including Medicare and commercial insurance. Section 1923(g) of the Act, as modified by the CAA 2021, includes an exception to this methodology for hospitals in and above the 97th percentile of all hospitals with respect to inpatient days made up of patients who, for such days, were entitled to Medicare Part A benefits and to supplemental security income (SSI) benefits (97th percentile hospitals). This exception, as described in section 1923(g)(2)(B) of the Act, applies to hospitals that are in or above the 97th percentile, either with respect to the number of inpatient days or percentage of total inpatient days that were made up of such days. The exception provides qualifying hospitals with a hospital-specific limit that is the higher of that calculated under the methodology in which costs and payments for Medicaid patients are counted only for beneficiaries for whom Medicaid is the primary payer, or the methodology in effect on January 1, 2020. From June 2, 2017, to the passage of the CAA 2021, payments made by all third-party payers (TPP), such as Medicare, other insurers, and beneficiary cost sharing, would all be included in the calculation of hospital-specific DSH limits, in accordance with the "DSH Payments—Treatment of Third-Party Payers in Calculating Uncompensated Care Costs" final rule in the April 3, 2017, **Federal Register** (82 FR 16114), which delineated the treatment of TPP and the calculation of hospital-specific DSH limits.

We acknowledge there are data limitations, which we describe later in this rule, that have delayed CMS' ability to clarify which hospitals qualify for the exception for 97th percentile hospitals. We proposed how we would determine which hospitals qualify for this exception and are finalizing as proposed.

3. Annual DSH Audits and Overpayments

The "Medicaid Program; Disproportionate Share Hospital Payments" final rule published in the December 19, 2008, **Federal Register** (73 FR 77904) (and herein referred to as the 2008 DSH audit final rule) sets forth the data elements necessary to comply with the requirements of

section 1923(j) of the Act related to auditing and reporting of DSH payments under State Medicaid programs. The regulations at 42 CFR 447.299(c) finalized in the 2008 DSH audit final rule outline 18 data elements States must submit to CMS, at the same time as the State submits the completed audit required under 42 CFR 455.304, to permit CMS verification of the appropriateness of such payments. One such data element is the total uncompensated care cost, which equals the total cost of care for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individuals and to individuals with no source of third-party coverage for the hospital services they receive, less the sum of other payment sources listed in § 447.299(c)(16). Despite the robust data, potential data gaps may exist as a result of an auditor identifying an area, or areas, in which documentation is missing or unavailable for certain costs or payments that are required to be included in the calculation of the total eligible uncompensated care costs.

Consequently, at times we are unable to determine whether a DSH overpayment to a provider has occurred, the root causes of any overpayments, and the amount of the overpayments associated with each cause. In current practice, an auditor may include a finding (or "caveat") in the audit, stating that the missing information may impact the calculation of total eligible uncompensated care costs, rather than making a determination of the actual financial impact of the identified issue. This lack of transparency results in uncertainty even if costs are ultimately correct and restricts CMS' and States' ability to ensure proper recovery of all FFP associated with DSH overpayments identified through annual DSH audits in instances where errors did occur.

In the past, the Office of Inspector General (OIG) and the Government Accountability Office (GAO) have raised concerns similar to ours regarding oversight of the Medicaid DSH program. The 2008 DSH audit final rule addressed concerns raised by OIG[3] by implementing in

[3] Audit of Selected States' Medicaid Disproportionate Share Hospital Programs," March 2006 (A-06-03-00031), *https://www.oig.hhs.gov/oas/reports/region6/60300031.pdf*.

regulations the independent certified audit requirements under section 1923(j) of the Act, by requiring States to include data elements as specified in § 447.299(c) with their annual audits. In 2012, GAO published the report "Medicaid: More Transparency of and Accountability for Supplemental Payments are Needed."[4] Although Medicaid DSH payments are not "supplemental payments," as described previously, they are akin to supplemental payments, and thus, GAO's report did not focus on supplemental payments exclusively. As part of the report, GAO analyzed the 2010 DSH audits for 2007 DSH payments and found DSH payments that did not comply with the audit requirements specified in part 455, subpart D. For each of the required DSH audit elements, there were a number of hospitals for which GAO could not determine compliance due to data reliability or documentation issues. For example, GAO could not determine compliance with the requirement that uncompensated care costs are accurately calculated for 33.7 percent of hospitals analyzed by GAO. The report highlights that, although the independent certified audit requirements have allowed us to identify various compliance issues and quantify some provider overpayments, in some instances, findings remain unquantified.

We agree with the report that more transparency is needed, but to obtain the necessary overpayment amounts under current reporting processes, CMS or the State would have to conduct a secondary review or audit, which would be burdensome and largely redundant. By requiring States to submit to CMS in the annual reports described in § 447.299(c) a dollar estimate of any Medicaid DSH provider overpayments, we ensure this calculation occurs with the primary audit and eliminates redundancy in reviewing documentation. As discussed further in section II. of this final rule, this is intended to further enhance our oversight to better ensure the integrity of hospital-specific limit calculations.

Amounts in excess of the hospital-specific limit are regarded as overpayments to providers, under 42 CFR part 433, subpart F. Section 1903(d)(2)(C) of the Act provides that,

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[4] *https://www.gao.gov/assets/660/650322.pdf.*

when an overpayment by a State is discovered, the State has a 1-year period to recover or attempt to recover the overpayment before an adjustment is made to FFP to account for the overpayment. FFP is not available for DSH payments that are found in the independent certified audit to exceed the hospital-specific limit. Currently, regulations in § 433.316 provide for determining the date of discovery of an overpayment, which is necessary to determine the statutory 1-year period, but it does not specify how this relates to the independent certified DSH audits required under section 1923(j)(2) of the Act and 42 CFR part 455, subpart D.

Accordingly, the discovery of overpayments necessitates the return of the Federal share, or redistribution by the State of the overpaid amounts to other qualifying hospitals, in accordance with the State's approved Medicaid State plan. While the preamble to the 2008 DSH audit final rule generally addressed the return or redistribution of provider overpayments identified through DSH audits, it did not include specific procedural requirements for returning or redistributing overpayments. Therefore, we have identified this area as an opportunity to strengthen program oversight and integrity protections, specifically with respect to the overpayment and redistribution reporting process and requirements for identifying the financial impact of audit findings. In the proposed rule, we proposed requirements to enhance these areas, which we are now finalizing as proposed.

4. DSH Health Reform Reduction Methodology

Section 2551 of the Affordable Care Act[5] (ACA) amended section 1923(f) of the Act to require aggregate reductions to State Medicaid DSH allotments annually from FY 2014 through FY 2020, to account for the then-anticipated decrease in uncompensated care resulting from expansions of coverage authorized by the ACA. The ACA specified in section 1923(f)(7)(B) of the Act certain factors CMS must consider in implementing these reductions and left certain components of the methodology to the Secretary of Health and Human Services to define (as

[5] Patient Protection and Affordable Care Act of 2010, Public Law 111–148, as amended by the Health Care and Education Reconciliation Act of 2010, Public Law 111-152.

described later in this section). The methodology is referred to as the DSH Health Reform Methodology (DHRM). We published a final rule in October 2013 that delineated a methodology to implement the annual reductions only for FY 2014 and FY 2015 to accommodate data refinement and methodology improvement for later reduction years. However, Congress has since modified section 1923(f)(7) of the Act several times such that the reductions have never taken effect. In the September 25, 2019, **Federal Register**, we published a final rule[6] (2019 final rule) delineating a revised methodology for the calculation of DSH allotment reductions, which at that time were scheduled to begin in 2020. Congress has since further delayed the start of these reductions until FY 2024. The CAA 2021 modified section 1923(f) of the Act such that the reductions occur from FY 2024 through FY 2027, in the amount of $8 billion each year.

Section 1923(f)(7) of the Act requires the Secretary to develop a methodology to determine the annual, State-by-State DSH allotment reduction amounts based on five factors: uninsured factor (UPF); Medicaid volume factor (HMF); uncompensated care factor (HUF); low DSH State factor (LDF); and the budget neutrality factor (BNF). The 2019 final rule assigned weights to the annual reduction amount for the three core factors: UPF, HMF, and HUF. The remaining two factors, the LDF and the BNF, affect the allocation of the reduction amounts within the three core factors. The LDF accomplishes this allocation at the front end of the calculations by shifting a portion of the reduction amount specified under section 1923(f)(7)(A)(ii) of the Act to non-low DSH States. Following this step, we determine the reduction calculations prescribed by the three core factors. We then perform additional reductions associated with the BNF within the HMF and HUF for States that divert DSH allotment amounts under section 1115 demonstrations. We then reallocate these reduction amounts away from States that do not divert DSH allotment amounts under section 1115 demonstrations, to comply with the aggregate reduction amounts specified under statute at

[6] 84 FR 50308.

section 1923(f)(7)(A)(ii) of the Act. The five factors are specified in section 1923(f)(7)(B) of the Act as follows:

- UPF – The statute requires that States with lower uninsurance rates receive higher percentage DSH reductions. Calculations performed under this factor utilize Census Bureau data that is subject to a 1-year lag.

- HMF – The statute requires that States that target DSH payments to hospitals with high Medicaid volume receive a lower percentage reduction in their DSH allotment. Calculations performed under this factor utilize DSH audit data that is on a 3-year lag.

- HUF – As required by statute, States that target DSH payments to hospitals with high levels of uncompensated care receive a lower percentage reduction in their DSH allotment. Calculations performed under this factor utilize DSH audit data that is on a 3-year lag.

- Low DSH State factor – Section 1923(f)(7)(B)(ii) of the Act requires that statutorily defined "low DSH States"[7] receive a lower overall DSH reduction percentage than non-low DSH States. To accomplish this, low DSH States and non-low DSH States are separated into two cohorts before applying the reduction methodology.

- BNF -- DSH allotment amounts diverted for coverage expansion under section 1115 demonstrations approved as of July 31, 2009, receive a limited protection from reduction.

5. Modernizing the Publication of Annual DSH and Children's Health Insurance Program (CHIP) Allotments

Section 447.297 provides a process and timeline for us to publish preliminary and final annual DSH allotments and national expenditure targets in the **Federal Register**. The current requirements specify that we publish DSH preliminary allotments and national expenditure targets by October 1 of each Federal fiscal year (FFY) and publish the final allotments and

[7] Section 1923(f)(5)(B) describes low DSH States as "State[s] in which the total expenditures under the State plan (including Federal and State shares) for [DSH] adjustments under this section for fiscal year 2000, as reported to the Administrator of the Centers for Medicare and Medicaid Services as of August 31, 2003, is greater than 0 but less than 3 percent of the State's total amount of expenditures under the State plan for medical assistance during the fiscal year."

national expenditure targets by April 1 of that FFY. We have found the current regulatory **Federal Register** publication process to be time consuming and administratively burdensome for us, and ultimately unnecessary in light of more timely notification practices already taking place.

Similarly, section 2104 of the Act provides appropriations for FY CHIP allotments for FYs 1998 through 2029. Regulations at 42 CFR 457.609 describe the process for calculating State CHIP allotments for a FY after FY 2008. Section 457.609(h) provides that CHIP allotments for a FY may be published as preliminary or final allotments in the **Federal Register** as determined by the Secretary. Similar to the current DSH allotment publication process, we have found the current FY CHIP allotment publication regulations administratively burdensome and less efficient than other means of notification. We proposed to codify the process already taking place while eliminating inefficient and duplicative publication requirements, and we are finalizing those proposals in this final rule.

II. Provisions of the Final Rule and Responses to Comments

A. When Discovery of Overpayment Occurs and its Significance (§ 433.316)

Section 1903(d)(2)(C) of the Act provides that, when an overpayment by a State is discovered, the State has a 1-year period to recover or attempt to recover the overpayment before an adjustment is made to FFP to account for the overpayment. Currently, regulations in § 433.316 provide for determining the date of discovery of an overpayment to a provider, which is necessary to determine the statutory 1-year period, in three distinct cases: (1)when the overpayment results from a situation other than fraud, under § 433.316(c); (2) when the overpayment results from fraud, under § 433.316(d); and (3) when the overpayment is identified through a Federal review, under § 433.316(e). It is not explicitly clear in the current regulations how the date of discovery is determined when an overpayment is discovered through the annual DSH independent certified audit required under § 455.304. Therefore, we believe a regulatory change is appropriate to specify the date of discovery of overpayments, as it relates to the annual DSH independent certified audit.

Accordingly, we proposed to redesignate paragraphs (f) through (h) of § 433.316 as paragraphs (g) through (i), respectively, and to add a new paragraph (f). In the new paragraph (f), we proposed that, in the case of an overpayment identified through the DSH independent certified audit required under part 455, subpart D, we would consider the overpayment as discovered on the earliest of either the date that the State submits the DSH independent certified audit report required under § 455.304(b) to CMS, or of any of the dates specified in § 433.316(c): paragraph (c)(1) (the date on which any Medicaid agency official or other State official first notifies a provider in writing of an overpayment and specifies a dollar amount that is subject to recovery); paragraph (c)(2) (the date on which a provider initially acknowledges a specific overpaid amount in writing to the Medicaid agency); and paragraph (c)(3) (the date on which any State official or fiscal agent of the State initiates a formal action to recoup a specific overpaid amount from a provider without having first notified the provider in writing). We noted that this change would afford more clarity concerning the independent certified DSH audit and the requirements on States based on those audits.

We received public comments on this proposal. The following is a summary of the public comments we received and our responses. Because of its relationship with the proposed provisions at § 447.299(f) and (g), which pertain to the treatment of overpayments, these topics overlapped in the comments received. Here, we specifically address comments that referenced the date of discovery, the aspect specific to this proposal, but recommend that the reader review and consider the comments received and our responses on all three provisions (that is, §§ 433.316(f) and 447.299(f) and (g)) in tandem.

Comment: A couple commenters were opposed to the date an overpayment is considered "identified" as being the date of audit submission. They cited issues such as a need to perform additional review and secondary auditing, or to adequately account for redistributions of Medicaid DSH payments in excess of the hospital-specific limit (if provided for under the State

plan), or to compute alternate payment methodologies for specialty hospitals that exceed the hospital-specific DSH limit.

Response: We are finalizing this provision as proposed. We understand the concern expressed by the commenters but disagree that the method for determining the date of discovery of an overpayment should be changed from the proposal. Finalizing the date of discovery to include the date the audit is submitted is consistent with our approach to determining the date that other overpayments are discovered as described in § 433.316(c). Specifically, § 433.316(c)(1) and (3) refer to the date on which a State official (or fiscal agent) first notifies a provider in writing of a specific overpayment amount subject to recovery or begins a formal action to recoup that amount without prior written notification. Section 433.316(c)(2) refers to the date on which a provider acknowledges a specific overpaid amount in writing to the State Medicaid agency. Each of these focuses on the date the State provides, or receives from a relevant third party, written notification (or initiates a recoupment action without prior written notification to the provider) of a specific overpaid amount. Similarly, the independent certified audit formalizes the identification of a specific overpayment amount when it is submitted. We also note that finalizing the date of State submission of the independent certified audit to CMS as an available date for discovery of an overpayment, as opposed to the date the State's auditor first identifies an amount to the State before the State submits the audit to CMS, affords the State an opportunity to review and make appropriate adjustments, as is typical with similar audit data. The State has up to 90 days after receipt of the independent certified audit to review it before it must be submitted to CMS in accordance with § 455.304(b) which we believe is ample time to review DSH audit findings and resolve any disagreement with the audit's contents and/or with overpayment determinations by working with the State's auditor.

In addition, we believe the concerns expressed by commenters are mitigated by other provisions we are finalizing in this rule at § 447.299(f) and (g). Specifically, by clarifying under § 447.299(f) that amounts identified in DSH audits that exceed the hospital-specific DSH limit

are to be treated as overpayments, States are afforded the opportunities provided under other overpayment circumstances, which includes the opportunity for a downward adjustment of an overpayment amount under § 433.320(c) as appropriate. This addresses concerns about the fact that the overpayment amount identified in an audit may be subject to change. In addition, we note that States have 2 years to complete redistributions under the provision we are finalizing at § 447.299(g), when in other circumstances, such as returning Federal share, a State only has 1 year to take action on an overpayment. This affords States ample time to compute and perform redistributions of payments to particular hospitals in excess of the hospital-specific DSH limit.

Finally, if a State plans to utilize an alternate payment methodology to address circumstances when a hospital may exceed its DSH limit, such as by decreasing supplemental payments, this methodology would need to be reflected in the State plan. Like DSH payment redistribution methodologies, a State should have this methodology in place well in advance of identifying DSH overpayments for a given year. We note that, in our experience, payment adjustments necessary to implement an alternate payment methodology typically are performed far in advance of the timing of the DSH audit for the relevant year. Nevertheless, if a State intends to utilize an alternate payment methodology in the event that overpayments are identified in a DSH audit, and that State has this methodology reflected in its State plan, we do not anticipate that the work necessary to implement the alternative payment methodology would be any more complex or burdensome than the work necessary to implement DSH overpayment redistribution methodologies; as such, we do not agree the possible existence of an alternate payment methodology would require more time for States once an overpayment is identified.

B. DSH Health Reform Reduction Methodology (§ 447.294)

As discussed in section I.B.4. of this final rule, section 1923(f)(7)(B)(iii) of the Act requires that the methodology for calculating each State's Medicaid DSH allotment reduction, as first established by the ACA, consider the extent to which the DSH allotment for a State was included in the budget neutrality calculation for a coverage expansion approved under section

1115 (that is, a section 1115 demonstration to provide coverage to individuals not otherwise eligible for Medicaid) as of July 31, 2009. In the 2019 final rule, we finalized a policy to exclude from DSH allotment reductions the amount of DSH allotment States had approved as of July 31, 2009, under a coverage expansion section 1115 demonstration. Any DSH allotment amounts included in budget neutrality calculations for non-coverage expansion purposes (for example, where DSH allotment amounts included in budget neutrality calculations have been used to match State expenditures for approved delivery system reform initiatives) under approved section 1115 demonstrations are still subject to reduction regardless of when they were approved. Further, the preamble to the 2019 final rule indicates that for any section 1115 demonstrations not approved as of July 31, 2009, these DSH allotment amounts included in budget neutrality calculations, whether for coverage expansion or otherwise, would also be subject to reduction. We note that all section 1115 demonstrations approved as of or before July 31, 2009, have expired and the protection does not apply to renewals or extensions of those section 1115 demonstrations. Therefore, there no longer exist any amounts related to coverage expansion to be excluded from future DSH allotment reductions scheduled to begin in FY 2024.

In the absence of DSH audit data relating to how States expend DSH allotment amounts diverted under section 1115 demonstrations, we propose to assign average HUF and HMF reduction percentages to these amounts.[8] We believe this approach is a reasonable method to determine reductions for the HUF and HMF factors, given the absence of relevant, hospital-specific DSH payment data for these payments. We considered using alternative percentages higher or lower than the average but settled on average percentages due to concerns that alternative percentages might provide an unintended benefit or penalty to these States for DSH diversions approved under a demonstration under section 1115 of the Act.

While the provisions of § 447.294(e)(12) are clear that we will assign average reductions to amounts associated with non-coverage expansion purposes in effect as of July 31, 2009, only

[8] 84 FR 50308 at 50328, wherein we discuss the policy to assign average amounts in the 2019 final rule.

the preamble to the 2019 final rule addresses the amounts diverted under a section 1115 demonstration approved after July 31, 2009. Additionally, the regulations are not specific regarding how these amounts are determined and accounted for in the DSH allotment reduction methodology. As such, we proposed to update the regulations at § 447.294(e)(12) to clearly specify that amounts diverted under a section 1115 demonstration approved after July 31, 2009, are subject to average reductions under the HUF and HMF so that the regulation may better reflect the policy finalized in the 2019 final rule preamble.

In addition, we proposed to remove the language, "for the specific fiscal year subject to reduction" in § 447.294(e)(12) introductory text and (e)(12)(i), because we are concerned that the current regulatory language could lead to anomalous results, as discussed later in this section. We proposed that the determination of diverted amounts that are subject to average reductions under the HUF and HMF would align with the State plan rate year (SPRY) for the DSH audits utilized in the DSH allotment reduction calculations, as specified in § 447.294(d), rather than the fiscal year subject to reduction. For example, when calculating the statutorily required DSH allotment reductions for FY 2024 (the fiscal year subject to reduction), we would utilize data from each State's SPRY 2019 DSH audit data because this would be the most recent data available to us. For States that do not divert their entire DSH allotment, we would include the amount of each State's DSH allotment diverted under a section 1115 demonstration for the time period that aligns with the associated SPRY (in this example, SPRY 2019). A discussion of States that divert their entire DSH allotment follows this discussion. Each State would then be assigned the average HUF and HMF reduction amounts for the State's respective State group based on this diverted amount.

Section 477.294(e)(12) introductory text and (e)(12)(i) currently align the amount of DSH allotment diverted under a section 1115 demonstration for a fiscal year with the fiscal year of the DSH allotment subject to reduction under section 1923(f)(7)(A)(ii) of the Act. We recognize that this non-alignment between the SPRY 2019 DSH audit data that we would use to

determine the HUF and HMF, and the FY 2024 section 1115 demonstration budget neutrality calculation diversion amount that would be used under the current regulation, could result in inappropriate and illogical outcomes. For example, in a case where a State claimed all or almost all of its DSH allotment amount for DSH expenditures for the SPRY DSH audit utilized in the DHRM (here, SPRY 2019), but later diverted a large portion of its DSH allotment amount under a section 1115 demonstration during a year subject to DSH allotment reductions (here, FY 2024), the State could receive a reduction on an amount (including both DSH payments and DSH allotment diverted under a section 1115 demonstration) that is excess of the amount available under its current DSH allotment subject to reductions. Therefore, we stated our belief that our proposed approach is reasonable because in the absence of DSH audit data relating to how States expend DSH allotment amounts diverted under section 1115 demonstrations, CMS will assign average HUF and HMF reduction percentages to these diverted amounts. As such, it is appropriate that the amounts diverted under section 1115 demonstrations should align with the SPRY of the DSH audit used in the DHRM and that the amounts subject to reduction do not exceed what States could have expended, either through DSH payments or diverted DSH allotment amounts, during the associated SPRY. We considered leaving the current regulatory text unchanged. However, we stated our belief it is important to update the current regulation in the interest of clarity and transparency and to avoid a potential outcome wherein a State might receive an inappropriately large reduction due to a misalignment of time periods for elements of the reduction methodology. Accordingly, we proposed to revise § 477.294(e)(12) introductory text to remove language indicating that the BNF and budget neutrality calculations are applied to each State's amount of DSH allotment diverted under a section 1115 demonstration "for the specific fiscal year subject to reduction." Further, we proposed to amend § 477.294(e)(12)(ii) to specify that the budget neutrality calculations are performed on the amount of each State's DSH allotment diverted under an approved section 1115 demonstration during the period that aligns with the associated SPRY DSH audit utilized in the DSH allotment reductions.

For States that divert their entire DSH allotment, and as such do not complete DSH audits, we are unable to use a DSH audit SPRY. Therefore, we proposed to apply reductions under the HMF and HUF to the DSH allotment that the State would have had available during the demonstration year (DY) coinciding with the SPRY DSH audits utilized in the DHRM. We also proposed to prorate the FFY allotment amount to determine this reduction in cases where the DY of the section 1115 demonstration crosses two FFYs. For example, as stated previously we would use SPRY 2019 DSH audit data for FFY 2024 DSH allotment reductions. However, if a State that diverts its entire DSH allotment has a DY that begins July 1, 2018, and ends June 30, 2019, we would have to determine the reduction amount associated with the diverted DSH allotment to reflect the amount of the FFY 2018 DSH allotment available from July 1, 2018, through September 30, 2018, and the amount of FFY 2019 DSH allotment available from October 1, 2018, through June 30, 2019. We stated that we did not believe it would be appropriate to calculate the reduction associated with the diverted DSH allotment using the full FFY 2019 DSH allotment because the diverted DSH funds would not have been available for the full DY ending June 30, 2019. For a State that diverts part of its DSH allotment, it would have a SPRY DSH audit already utilized in the DHRM. We would use the diverted DSH amount from the same SPRY, which may also involve prorating diverted DSH amounts from a DY, depending on whether the DY as specified in the section 1115 demonstration aligns with the SPRY. In previous rulemaking, we proposed and finalized a policy to utilize the most recent year available for all data sources and to align the SPRY of data sources whenever possible.[9] Providing this clarification in regulation through this rulemaking would accomplish this goal.

We received public comments on these proposals. The following is a summary of the public comments we received and our responses.

Comment: One commenter suggested that CMS use hospital-specific section 1115 supplemental payment data in measuring DSH targeting factors for diversion funds as the

[9] 82 FR 35155 at 35157; 84 FR 50308 at 50322.

commenter was concerned that using averages would not encourage States to target DSH payments to the hospitals that need them the most. The commenter also added that CMS is statutorily required to collect hospital-specific data under section 1115 demonstrations in accordance with division CC, title II, section 202 of the CAA, 2021 (herein referred to as section 202). The commenter appears to be under the impression that the supplemental payment reporting requirement under section 202 applies to DSH payments.

Response: We thank the commenter for the suggestion. However, this recommendation is outside the scope of the proposed rule, so implementing it would require further rulemaking. Our current regulations at § 447.294(e)(12) and (13) specify that DSH diversion amounts paid under a section 1115 demonstration will receive average reduction amounts, for the respective State group (that is, low DSH and non-low DSH), under the HMF and HUF. We did not propose to amend this aspect of § 447.294(e)(12) and (13), so changes to this calculation are beyond the scope of this rule. Further, the detailed supplemental reporting required under section 202 would not apply to the demonstration year DSH diversion payments that we proposed to align with the SPRY DSH audit data for use in the DHRM for DSH allotment reductions for several years. The new reporting requirements in section 1903(bb)(1)(B) of the Act, as amended by section 202 of the CAA 2021, do not apply to payments made before October 1, 2021. We will calculate the statutorily required DSH allotment reductions utilizing the most recently available DSH audit information and will align amounts diverted under section 1115 demonstrations with the SPRY of the DSH audit used in the DHRM. Therefore, the detailed supplemental payment reporting data required under section 202 will be available starting with the FY 2022, which would align with the SPRY 2022 DSH audit data. Given the timelines associated with the submission of the independent certified audit, which must be completed by September 30 of the year ending three years from the respective Medicaid SPRY and submitted to CMS by December 31 of that year, we could not utilize this required data any earlier than to calculate the DSH allotment reductions scheduled for FY 2027, the last year of currently scheduled DSH allotment reductions. As such,

we would not have this reporting information available to calculate the DSH allotment reductions for FY 2024 through FY 2026. Moreover, the HUF calculations require additional information which is not required under section 202 but that is available in the SPRY DSH audits.

We are finalizing the provision as proposed, with a minor phrasing change to § 447.294(e)(12) replacing "pursuant to" with "in accordance with" to align with current style guidelines.

C. Hospital-specific Disproportionate Share Hospital Payment Limit (§ 447.295)

From June 2, 2017 to October 1, 2021 (the effective date of the CAA 2021), costs and payments for hospital services furnished to beneficiaries who were eligible for Medicaid, even when there was a third-party payer such as Medicare or other insurer that pays primary to Medicaid for inpatient and outpatient hospital services, would all be included in the calculation of Medicaid shortfall portion of the hospital-specific DSH limits in accordance with the "DSH Payments—Treatment of Third-Party Payers in Calculating Uncompensated Care Costs" final rule in the April 3, 2017, **Federal Register**. Since October 1, 2021, the amendments to section 1923(g) of the Act made by section 203 of the CAA 2021 changed the methodology for calculating the Medicaid shortfall portion (Medicaid costs less Medicaid payments) of the hospital-specific DSH limit to only include costs and payments for hospital services furnished to beneficiaries for whom Medicaid is the primary payer. Additionally, the CAA 2021 amended section 1923(g)(2) of the Act to provide an exception for certain hospitals that are in the 97th percentile or above of all hospitals with respect to the number of Medicare SSI days (that is, inpatient days made up of patients who, for such days, were entitled to Medicare Part A benefits and to SSI benefits) or percentage of Medicare SSI days to total inpatient days. In § 447.295(b), we proposed to add the definition of "97th percentile hospital" to mean a hospital that is in at least the 97th percentile of all hospitals nationwide with respect to the hospital's number of Medicare SSI days or percentage of inpatient days that are Medicare SSI days, for the hospital's

most recent cost reporting period. For hospitals that meet this criteria, section 1923(g)(2)(A) of the Act specifies that the hospital-specific DSH limit is the higher of the amount determined under the methodology as amended by section 203 of the CAA 2021 or the amount determined under the methodology in effect on January 1, 2020 (described previously), which we proposed to implement in paragraph (3) of the definition of hospital-specific DSH limit calculation in § 447.295(d). As further discussed later in this section, we also proposed in the definition of 97th percentile hospital that CMS would identify the 97th percentile hospitals, for each Medicaid SPRY beginning on or after October 1, 2021, using Medicare cost reporting and claims data sources, as well as supplemental security income eligibility data provided by the Social Security Administration. We stated that we would publish lists identifying each 97th percentile hospital annually in advance of October 1 of each year and would revise a published list only to correct a mathematical or other similar technical error that is identified to CMS during the one-year period beginning on the date the lists are published.

We also explained in the preamble to the proposed rule that we interpreted these new requirements to be applicable for SPRYs "beginning on or after" October 1, 2021, the effective date of the CAA 2021. Previously, certain statutory references to "fiscal year," such as in section 1923(g)(1) and (2) and (j)(1) of the Act, have also been interpreted as referring to each State's SPRY, instead of the FFY, when establishing requirements for the hospital-specific DSH limit (and audit requirements to ensure that payments comply with hospital-specific DSH limits). In the 2008 DSH audit final rule, CMS indicated that this interpretation was in "recognition of varying fiscal periods between hospitals and States" and that "[t]he Medicaid [SPRY] is the period which each State has elected to use for purposes of DSH payments and other payments made in reference to annual limits." Further, we stated our belief that interpreting this provision to be applicable on an FFY basis would impose an excessive burden on States and hospitals. In particular, we explained our belief that such an interpretation would create a significant burden in situations when a hospital would qualify to meet the exception for 97th percentile hospitals for

a portion of its SPRY, but not for the full SPRY, if qualification were determined on the basis of the FFY. This result would be likely to occur, given that the majority of States have SPRYs that do not align with the FFY. In these instances, States would need to prorate the uncompensated care costs, for affected hospitals, within a SPRY accordingly since the methodology for calculating the Medicaid shortfall portion of the hospital-specific DSH limit may not be consistent for the entire SPRY if the hospital qualified as a 97th percentile hospital for only a portion of the SPRY. As such, we proposed that section 203 of the CAA 2021, including the 97th percentile exception, be effective starting with each State's first SPRY beginning on or after October 1, 2021. For example, if a State's SPRY begins July 1, then the amendments made by section 203 of the CAA 2021 would be effective starting with the SPRY beginning July 1, 2022. Conversely, if a State's SPRY begins each year on October 1, then such amendments would be effective starting with the SPRY beginning October 1, 2021.

Hospitals meeting the definition of a 97th percentile hospital, and therefore, qualifying for the 97th percentile exception will, by statute, calculate their hospital-specific DSH limit using the higher value of either the hospital-specific DSH limit amount determined for the hospital under section 1923(g)(1)(A) of the Act as amended by section 203 of the CAA 2021, or the amount determined for the hospital under section 1923(g)(1)(A) of the Act as in effect on January 1, 2020. Where section 1923(g)(2)(A)(ii) of the Act, as amended by section 203 of the CAA 2021, refers to "the amount determined for the hospital under paragraph (1)(A) as in effect on January 1, 2020," we interpret this to refer to the hospital-specific limit calculation methodology that was in effect on January 1, 2020, and not the specific dollar amount that was applicable on that date.

We proposed to revise § 447.295(d) to reflect the statutory changes made by section 203 of the CAA 2021 to update the methodology for the calculation of the hospital-specific DSH limit to only include costs and payments for hospital services furnished to beneficiaries for whom Medicaid is the primary payer. In addition, we proposed to revise § 447.295(d) to specify

the methodology that hospitals meeting the exception for 97th percentile hospitals would utilize in the calculation of the hospital-specific DSH limit. Specifically, in § 447.295(d)(1), we proposed to specify that for each State's Medicaid SPRYs beginning prior to October 1, 2021 and subject to proposed paragraph (d)(3), only costs incurred in providing inpatient hospital and outpatient hospital services to Medicaid individuals, and revenues received with respect to those services, and costs incurred in providing inpatient hospital and outpatient hospital services, and revenues received with respect to those services, for which a determination has been made in accordance with § 447.295(c) that the services were furnished to individuals who have no source of third-party coverage for the specific inpatient hospital or outpatient hospital service are included when calculating the costs and revenues for Medicaid individuals and individuals who have no health insurance or other source of third-party coverage for purposes of section 1923(g)(1) of the Act.

In § 447.295(d)(2), we proposed to specify the applicable costs and revenues associated with services furnished to Medicaid individuals and individuals who have no health insurance or other source of third-party coverage for purposes of determining the hospital-specific DSH limit under section 1923(g)(1) of the Act. We proposed that for each State's first Medicaid SPRY beginning on or after October 1, 2021, and thereafter, subject to proposed paragraph (d)(3), only costs incurred in providing inpatient hospital and outpatient hospital services to Medicaid individuals when Medicaid is the primary payer for such services, and revenues received with respect to those services, would be included in the Medicaid shortfall portion of the hospital-specific DSH limit calculation. Furthermore, we proposed to specify that only costs and revenues for which a determination has been made in accordance with § 447.295(c) that the services were furnished to individuals who have no source of third-party coverage for the specific inpatient hospital or outpatient hospital service would be included in the uninsured shortfall portion of hospital-specific DSH limit calculation.

As noted previously, we proposed to implement the 97th percentile hospital exception in proposed § 447.295(d)(3), which would specify that, effective for each State's first Medicaid SPRY beginning on or after October 1, 2021, and thereafter, the hospital-specific DSH limit for a 97th percentile hospital defined in proposed paragraph (b) would be the higher of the values from the calculations described in proposed paragraphs (d)(1) and (2).

We also proposed to develop a data set (compiling cost report, claims, and eligibility data) to determine which hospitals, ranked on a national level, qualify to meet the statutory 97th percentile hospital exception. We proposed to publish these data for use in determining which hospitals qualify as a 97th percentile hospital on an annual basis, electronically or in another format as determined by CMS, prior to the SPRY to which the data would apply. We would determine which hospitals qualify as a 97th percentile hospital on an annual basis prior to each SPRY beginning on or after October 1. In this way, we explained that we would be able to qualify hospitals on the basis of SPRYs, while also accounting for non-alignment of SPRYs across States. Again, this would not be done on the basis of the FFY, but rather would be an annual process to qualify hospitals for each SPRY. We indicated that we would publish these data once a year, prior to October 1. Each State could then use these data to determine which hospitals qualify for the 97th percentile hospital exception for the State's SPRY that begins between that October 1 and September 30 of the following calendar year.

We proposed to determine a hospital's qualification for the 97th percentile exception for each SPRY on a prospective basis. We explained our belief that this is a reasonable interpretation in that the statute specifically refers to the "most recent cost reporting period" in determining a hospital's qualification “for the fiscal year,” which, as noted, we interpret to mean SPRY. That is, we believe it is reasonable to interpret the reference to the “most recent cost reporting period” in section 1923(g)(2)(B) of the Act to mean the most recent cost reporting period for which there is a cost report available before the beginning of the SPRY for which the 97th percentile hospitals are being identified.

By applying this exception prospectively, we eliminate the need to retroactively rank and qualify hospitals based on actual Medicare SSI days and ratios for services furnished during the SPRY. This application would allow for States and hospitals to know prior to the beginning of the SPRY which hospitals qualify for the exception. That knowledge would allow States and hospitals to gauge how payments should be made and measured against hospital-specific DSH limits and provide greater payment predictability than a retroactive application. We believe this interpretation to also be the most feasible from an operational standpoint for CMS, States, and hospitals.

To compile this source of data, we explained that we would use data originating from various systems and sources, including the Healthcare Cost Report Information System (HCRIS) and Medicare Provider Analysis and Review (MEDPAR) files, and SSI eligibility data from the Social Security Administration (SSA). Utilizing HCRIS, we would identify the universe of hospitals that have filed a Medicare cost report and each hospital's most recent cost reporting period, including acute care hospitals paid under the inpatient prospective payment system (IPPS), critical access hospitals, inpatient rehabilitation facilities, and inpatient psychiatric facilities.

We explained that we would then determine each hospital's Medicare SSI days for discharges occurring in the hospital's most recent cost reporting period, regardless of the length of that cost reporting period, using a data set that combines MEDPAR claims data and SSI eligibility data. We would utilize Medicare SSI days for discharges occurring in the cost reporting period, rather than Medicare SSI days occurring within the cost reporting period because the MEDPAR data show the Medicare SSI day count for each inpatient stay as a whole. This approach is consistent with how Medicare uses these data to develop the Medicare SSI days ratios for Medicare DSH purposes. Section 1886(d)(5)(F)(vi) of the Act, in describing the Medicare SSI percentage within the Medicare "disproportionate patient percentage," refers to the "number of such hospital's patient days for such period." Then, the implementing regulations at

42 CFR 412.106 describe the Medicare SSI days used for Medicare DSH as patient days that "are associated with discharges that occur during that period." This approach means if an inpatient stay begins in one cost reporting period but ends in the next cost reporting period, we would not count any of the inpatient stay's days toward the day count for the first cost reporting period, but instead count all of this inpatient stay's days toward the day count for the second cost reporting period. This approach does not favor the counting of days in one cost reporting period over others. On average, exclusion of days for inpatient stays that straddle between one cost reporting period and the hospital's next cost reporting period would be offset by any inclusion of days for inpatient stays that straddle between that one cost reporting period and the hospital's previous cost reporting period. Therefore, we can ensure we do not overinclude or underinclude Medicare SSI days for inpatient stays that straddle two cost-reporting periods.

To determine each hospital's percentage of Medicare SSI days to total inpatient days, we proposed that we would divide the Medicare SSI days by each hospital's total inpatient days for that same cost reporting period from HCRIS to obtain a percentage. We would then compile two lists—one that ranks the hospitals based on the absolute number of Medicare SSI days and another that ranks them by the percentage of inpatient days that are Medicare SSI days, respectively. A hospital may qualify to meet the 97th percentile exception based on its rankings on either of the two lists.

We proposed to utilize the Medicare SSI days and total inpatient days data to mathematically determine a threshold of acceptance to identify hospitals meeting the 97th percentile exception. The array includes either the values of Medicare SSI days or the percentage of inpatient days that are Medicare SSI days, for the universe of hospitals nationwide identified through this data process. For the Medicare SSI days, the 97th percentile threshold would be rounded to the nearest whole number, with x.5 or higher rounded up, and less than x.5 rounded down. Any hospital with Medicare SSI days for its most recent cost reporting period greater than or equal to the 97th percentile threshold would qualify as a 97th percentile hospital.

For the percentage of inpatient days that are Medicare SSI days, all values would be rounded to the fourth decimal place (0.xxxx, alternatively stated as xx.xx percent), including each hospital's own percentage and the 97th percentile threshold. Values of 0.xxxx5 or higher would be rounded up, and less than 0.xxxx5 would be rounded down. Any hospital that has a percentage of total inpatient days that are Medicare SSI days from its most recent cost reporting period that is greater than or equal to the 97th percentile threshold would qualify as a 97th percentile hospital. We proposed that the ranking would be on a national level, as the statutory language under section 203 of the CAA 2021 refers to "97th percentile of all hospitals," which we believe is most consistent with a national, rather than a State-level ranking.

To follow the statutory requirement to utilize information from the most recent cost reporting period, we proposed to utilize each hospital's most recent cost reporting period for which there is a filed cost report in HCRIS, at a particular point in time in advance of the SPRY to which the 97th percentile qualification would apply. A filed cost report would first have an "as submitted" status in HCRIS, which subsequently would change to "amended," "settled without audit," "settled with audit," or "reopened" status, which indicates a final report that was previously reopened and re-settled. We considered utilizing the most recent settled cost reporting period, but we explained that we had determined that the use of the as-submitted cost report would result in the use of more current and more consistent reporting periods across hospitals, consistent with the statutory directive to rely on “the most recent cost reporting period.” Moreover, we explained that we had determined that the total inpatient days seldom change between the as-submitted and the settled cost reports. The total inpatient days count is the primary data element needed from the cost report in order for us to determine which hospitals meet the 97th percentile exception. However, if the most recent cost reporting period for which there is an as-submitted cost report happens to already have an amended cost report, a settled cost report, or a reopened cost report as of the date that CMS obtains data from HCRIS for use in determining which hospitals meet the 97th percentile hospital exception, we proposed that we

would use the total inpatient day count from the amended cost report, settled cost report, or reopened cost report for that period because that is the most updated information available for that period.

In the proposed rule, we described the cost report status changes, from the cost report's initial submission to its potential reopening after settlement. Consistent with that expected workflow, when there is more than one cost report for a hospital for its most recent cost reporting period in the HCRIS database as of the snapshot date, we will select the latest cost report based on the following order of the cost report status codes as they appear in HCRIS, from earliest to latest: 1 (as submitted), 5 (amended), 2 (settled without audit) or 3 (settled with audit), 4 (reopened). If there happens to be both a "settled without audit" cost report record and a "settled with audit" cost report record for a hospital for the same cost reporting period in the HCRIS database, we will determine the later of the two based on the date that record is processed into HCRIS, consistent with our stated intention to use the most up-to-date information available as of the snapshot date. We also noted that we have observed in rare cases that, for a given cost reporting period, a hospital may have one or more versions of the cost report (that is, "amended," "settled without audit," "settled with audit," and/or "reopened") without having the initial version of the cost report ("as submitted") in the HCRIS database as of the snapshot date. Regardless, as long as the cost reporting period is the most recent period for which a cost report record exists for the hospital in the HCRIS database, we will follow the sorting order described above in choosing the latest cost report from the relevant cost reporting period.

We proposed to utilize both covered and non-covered Medicare Part A days when collecting data and calculating hospital percentiles. The statutory language in section 1923(g)(2)(B)(i) of the Act as modified by section 203 of the CAA 2021 specifically refers to patients who were entitled to benefits under part A of title XVIII. A patient's status as entitled to benefits under part A of title XVIII does not depend on whether payment for a particular inpatient day was available under Medicare Part A payment principles, and a qualifying

Medicare beneficiary remains entitled to benefits under Part A even if Medicare payment is not available with respect to a particular inpatient day.[10] As such, we believe the calculations must include all Medicare Part A inpatient days, whether covered or non-covered. Further, this is consistent with CMS' use of covered and non-covered days in the Medicare SSI days ratio calculations for Medicare DSH payment purposes under section 1886(d)(5)(F)(vi)(I) of the Act, which describes a hospital's inpatient days for patients who were entitled to benefits under part A of title XVIII and were entitled to SSI benefits under title XVI of the Act.

Hospitals may provide acute inpatient hospital services, as well as other inpatient hospital services, in distinct part units of the hospital. The distinct part units of a hospital that provide inpatient hospital services, which are reported separately on the hospital's Medicare cost report, are rehabilitation distinct part units and psychiatric distinct part units. We proposed to include all inpatient days for inpatient hospital services reported on each hospital's Medicare cost report, including days furnished in distinct part units of the hospital that provide inpatient hospital services, for purposes of determining a hospital's Medicare SSI days and total inpatient days. We note that Medicare pays for services furnished in these distinct part units under different payment systems from the acute care inpatient hospital services provided by the hospitals. However, for Medicaid purposes, the DSH uncompensated care costs of the hospital are inclusive of the costs of inpatient and outpatient hospital services furnished by the hospital, including those furnished in these distinct parts. Therefore, we believe the hospital's Medicare SSI days and total inpatient days should be inclusive of these distinct part unit days and not limited to acute inpatient hospital days. In this final rule, we are also clarifying that days in which a swing bed in a hospital, including a critical access hospital, is used for skilled nursing facility or nursing facility services are not to be included in determining a hospital's Medicare SSI days and total inpatient days, because those days are for nursing facility services rather than inpatient hospital services.

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[10] *See Becerra v. Empire Health Found., for Valley Hosp. Med. Ctr.*, 142 S. Ct. 2354 (2022).

In determining when we can begin to collect and assemble the necessary data prior to the beginning of each upcoming SPRY that begins on or after October 1 each year, we proposed to use HCRIS data as it exists as of March 31, in advance of October 1 of that same calendar year. Using the HCRIS data as of March 31, we explained that we would identify each hospital's most recent cost reporting period for which the hospital has an available cost report and also identify the total inpatient days from the latest cost report available for that most recent cost reporting period. We also proposed to use the latest available MEDPAR files and SSI eligibility data, as of the same March 31 date, to determine the Medicare SSI days data that correspond to that same most recent cost reporting period for each hospital.

For example, for the 97th percentile determination applicable to SPRYs beginning October 1, 2023, through September 30, 2024, (that is, SPRYs beginning during FFY 2024), we explained that we would determine a hospital's most recent cost reporting period in which it has a cost report in HCRIS as of March 31, 2023. For instance, if a hospital's most recent cost reporting period with a cost report in HCRIS as of March 31, 2023, is from July 1, 2021, to June 30, 2022, we would take the total inpatient day count from that cost report. Then we would utilize the MEDPAR files and SSI eligibility data available as of March 31, 2023, to determine the hospital's Medicare SSI days for the discharges occurring in that same cost reporting period of July 1, 2021, to June 30, 2022.

We explained that using the most recently available data as of March 31 in advance of October 1 each year would allow us a reasonable 6-month timeframe to pull data from each of these data sources, address any potential data issues, complete the necessary compiling and calculations, perform any data integrity checks, determine the 97th percentile and the hospitals meeting the threshold based either on the Medicare SSI days or the percentage of total inpatient days that are Medicare SSI days, and make the results available prior to October 1. States would then have the 97th percentile results applicable to the State's SPRY that begins between October 1 of that calendar year and September 30 of the following calendar year. The March 31 date

would establish a snapshot for a point in time each year that is reasonably close to October 1 of that same calendar year that we would use to determine what is the "most recent" data available for application to the upcoming SPRYs, while allowing us sufficient time to process the data and make the results available before the start of those SPRYs. We want to make clear that the March 31 snapshot date is not the actual date we will be pulling the cost report data from HCRIS, but rather the date by which a cost report must be processed into HCRIS to be captured. Prospectively, we may pull the cost report data anytime over the 6 months following the March 31 snapshot date. Similarly, for the Medicare SSI days, we will use MEDPAR claims data with matched SSI eligibility data for claims processed through the March 31 snapshot date. Again, prospectively, we may pull the Medicare SSI days data from this MEDPAR snapshot for each hospital's relevant cost reporting period anytime over the 6 months following the March 31 snapshot date. Note, for the 97th percentile determination for SPRYs beginning during FFYs 2022, 2023, and 2024, we are pulling the data at the time we are finalizing this rule, to allow for public release of the 97th percentile hospital lists shortly after the issuance of this final rule.

Given the timing of this rulemaking and the October 1, 2021, effective date of the amendments made by section 203 of the CAA 2021, we proposed to produce the 97th percentile hospital data for both SPRYs beginning during FFY 2022 and SPRYs beginning during FFY 2023 using the necessary Medicare SSI days and cost report information as it would have been available to us under the timelines in the proposed rule. For example, for the data necessary to determine hospitals meeting the 97th percentile exception for SPRYs beginning during FFY 2022, we proposed that we would obtain a snapshot of the HCRIS, MEDPAR, and SSI eligibility data as would have been available on March 31, 2021.

While we proposed to include all hospitals that provide Medicaid-covered inpatient services and file a Medicare cost report in our data set, we noted that there would be circumstances resulting in some hospitals being omitted from the data set. We explained that we would begin gathering all necessary data after March 31 of each year, based on the data

availability described previously, to develop the data set to rank and indicate which hospitals qualify to meet the 97th percentile hospital exception for each State's upcoming SPRY that begins on or after October 1 of that year. In accordance with 42 CFR 413.24(f)(2), cost reports are generally due 5 months from the end of each hospital's cost-reporting period. For example, a hospital with a cost reporting year end of September 30 would generally be expected to file a cost report by the end of February the following year, while a hospital with a cost reporting year end of June 30 would generally be expected to file its cost report by the end of November of that year. However, we also wanted to build in a reasonable window for late filing and cost report processing into HCRIS. Therefore, we proposed to include in the data set any hospital that has filed a cost report dating back to at least September 30, 3 years prior to capture as many hospitals as possible in our data set. We explained that it is unlikely that there would be a delay greater than 3 years from when a hospital's cost report is generally due to when that cost report is captured in HCRIS. For example, when we begin the data development process for data available through March 2023, we would exclude a hospital from the data set that does not have a cost report in HCRIS from a cost reporting period ending by September 30, 2020, or later. We proposed this cutoff to capture as many hospitals in our data set as possible, but to also prevent significant variability in the cost-reporting periods by excluding Medicare hospitals whose most recent cost-reporting period for which there is a cost report in HCRIS dates back more than 3 years. This cutoff is intended to help exclude hospitals that may be inactive or terminated from our data set.

As noted earlier in this section, we also proposed to include in the data set only hospitals that file a Medicare cost report. Because the Medicare cost report data are the source of total inpatient days, it is necessary for a hospital to file a Medicare cost report to calculate a hospital’s Medicare SSI day as a percentage of total inpatient days. We explained that we cannot perform the calculations without this cost report information. Therefore, we proposed to include only hospitals that file a Medicare cost report in the data set. Section 1923(g)(2)(B) of the Act

recognizes the necessity of the Medicare cost report for the implementation of the 97th percentile exception by basing the qualification for the exception on the number or percentage of Medicare SSI days for the "most recent cost reporting period." Therefore, we explained our belief that it is appropriate and consistent with the statutory requirements to include only these hospitals that have submitted Medicare cost reports in the data set for both 97th percentile exception lists. We noted that we did not anticipate this to be a problem, since any hospital serving Medicaid patients but that does not file a Medicare cost report, would not qualify for the 97th percentile hospital exception. In accordance with § 413.24(f), Medicare-participating hospitals are required to file cost reports, which are generally due 5 months after the close of each cost reporting period. In accordance with Medicare Provider Reimbursement Manual, Part II, Section 110, hospitals with no Medicare utilization do not need to file a cost report, and hospitals meeting low Medicare utilization thresholds may file a less than full cost report with limited information. Because a hospital would only qualify for the 97th percentile hospital exception with a relatively high volume of Medicare SSI days, a hospital with no or low Medicare utilization, and therefore, with no cost report or with a less than full cost report which would not have inpatient days data, would not qualify for the 97th percentile hospital exception.

Given that we proposed to use snapshot cost report, claims, and eligibility data in advance of October 1 each year to produce nationwide lists applicable for each State's upcoming SPRY beginning on or after that October 1, we proposed that we would not modify the 97th percentile qualification results based on a request by one or more individual hospitals (or by one or more States, with respect to one or more individual hospitals) to update or reconsider hospital cost report, claims, or eligibility data. The snapshot approach recognizes that, at a given point in time, a hospital's most recent cost reporting period for which there is a cost report available in HCRIS, as well as the hospital's number of total inpatient days as reported in that most recent cost report and number of Medicare SSI days as determined from MEDPAR and SSI eligibility data sources, may be subject to future revision. However, to determine qualification for the 97th

percentile hospital exception, we must select a point in time to capture snapshot data, and the resulting lists must provide reasonable certainty to hospitals and States nationwide regarding which hospitals qualify for the exception. We do not believe it would be prudent or reasonable to continuously revisit the 97th percentile hospital qualifications based on changing cost report, claims, or eligibility data, outside of the snapshot parameters established in this final rule.

Nonetheless, we recognized in the proposed rule that there is a possibility of a mathematical or other similar technical error by CMS that could lead to a misidentification of the hospitals that qualify for the 97th percentile exception. In such a circumstance, we noted our belief that it would be appropriate for us to correct our error, recognizing that this could result in some hospitals being determined eligible for the 97th percentile hospital exception that previously (erroneously) were not so listed, and other hospitals losing their previous (erroneous) designation as qualifying for the exception. At the same time, we observed that we must balance this consideration with the recognition that the published lists will be relied upon by States and hospitals for identifying which hospitals qualify for the exception, hospital-specific limits will be set accordingly, and DSH payments will be made; all interested parties (including hospitals, the States, and CMS) have an interest in finality for these payments after a reasonable time. Accordingly, we proposed to allow 1 year from the posting of the 97th percentile hospital lists for States, hospitals, CMS, or other interested parties to identify any mathematical or other similar technical error made by CMS, according to instructions that would appear on the published lists. Upon CMS verification that an error occurred that affected the hospitals appearing on a list of 97th percentile hospitals for a given year, we would determine and publish a revised list as soon as practicable. We noted our belief that 1 year is a reasonable timeline for identifying any mathematical or other similar technical error made by CMS and would also allow a corrected qualifying list to be available in advance of the start of the independent DSH audit for the respective SPRY in most instances. For example, if we publish the qualifying lists in 2023 for application retroactively to a SPRY that begins October 1, 2021 (that is, SPRY 2022),

we would post a corrected qualifying list, if necessary, sometime in 2024. Then, when the independent audit is performed for that SPRY in 2025, the final 97th percentile qualification lists would be available and not subject to any further changes. Accordingly, in paragraph (2) of the proposed definition of 97th percentile hospital in § 447.295(b), we proposed that CMS would publish lists identifying each 97th percentile hospital annually in advance of October 1 of each year. We proposed that CMS would revise a published list only to correct a mathematical or other similar technical error made by CMS that is identified to CMS during the one-year period beginning on the date the list is published.

We proposed that the effective date for this and other CAA 2021-related proposals, noted in the respective sections, be applicable to fiscal years beginning on or after October 1, 2021, to align with the effective date of the CAA 2021.

We received public comments on these proposals. The following is a summary of the public comments we received and our responses.

Comment: Many commenters expressed opposition to the statutory changes required under section 203 of the CAA 2021. Commenters expressed concerns regarding the financial impact to hospitals that anticipated decreases in the hospital-specific DSH limits will have on hospitals and their ability to provide services. Two commenters indicated that the exception for 97th percentile hospitals was not adequate to protect financially vulnerable hospitals. A commenter indicated that they believe the 97th percentile threshold is arbitrary. Another commenter expressed the opinion that the methodology specified under section 203 of the CAA 2021 incorrectly assumes that hospitals receive the entirety of a Medicare or Medicaid payment rate, and explained that, due to how a particular State may limit Medicaid payment of Medicare cost sharing amounts, hospitals are not paid the full payment for care provided to patients dually eligible for Medicare and Medicaid. A commenter noted the projected financial loss that would be incurred under the new methodology in which costs and payments for Medicaid patients are counted only for beneficiaries for whom Medicaid is the primary payer for hospitals that care for

a high number of Medicaid/SSI-eligible beneficiaries with complicated health care needs. The commenter pointed out that many of those Medicaid eligible individuals who are disabled will also become eligible for Medicare after a 2-year waiting period, making the costs associated with their care ineligible for inclusion in the new hospital-specific DSH limit calculation. Commenters urged CMS to monitor the financial impacts to hospitals and to work with Congress to mitigate the potential negative effects of section 203 of the CAA 2021.

Response: We appreciate the impact that the statutory changes made by section 203 of the CAA 2021 may have on hospitals. States' policies for Medicaid payment of Medicare cost sharing amounts for dually eligible beneficiaries do vary, and we acknowledge that there could be uncompensated care costs after all applicable Medicare and Medicaid payments; with the statutory changes, such uncompensated care costs would not be included in the hospital-specific DSH limit to the extent that Medicare, not Medicaid, is the primary payer of such services. However, we are required by statute to implement the new methodology for determining hospital-specific DSH limits, including the exception for 97th percentile hospitals, as specified under section 1923(g) of the Act. We do note that, despite the statutory changes made by section 203 of the CAA 2021, there remains considerable flexibility for States in setting DSH State plan payment methodologies to the extent that these methodologies are consistent with section 1923(c) of the Act and all other applicable statutes and regulations. However, we intend to continue to monitor the financial impact that these statutory changes have on hospitals and provide information and technical assistance as Congress may request, as necessary to address any negative impact on providers.

Comment: Several commenters expressed support for the proposals to implement the amendments made by section 203 of the CAA 2021, to the hospital-specific DSH limit calculations for the Medicaid shortfall calculation to include only Medicaid costs and payments when Medicaid is the primary payer. One commenter commended CMS for engaging in rulemaking to address the statutory requirements.

Response: We appreciate the support.

Comment: Several commenters requested clarification regarding how CMS defines "primary payer" and when Medicaid is considered to be the primary payer for inpatient and outpatient hospital services provided to Medicaid beneficiaries.

Response: This rule does not change existing rules related to Medicaid's status as primary payer for a particular service. This rule addresses the calculation of hospital-specific limits as amended by section 203 of the CAA 2021. This limits the Medicaid shortfall to the costs and payments associated with inpatient and outpatient services where Medicaid is the primary payer, providing an exception for 97th percentile hospitals. We will continue to rely on existing rules governing third party liability and when Medicaid is a primary payer, such as those at section 1902(a)(25)(A) of the Act and §§ 433.135 through 433.154. Medicaid is generally the "payer of last resort," meaning that Medicaid only pays claims for covered items and services if there are no other liable third-party payers for the same items and services, which concept is implied in the above statute and regulations.[11]

In the proposed rule, we also stated that for purposes of calculating the hospital-specific DSH limit, section 203 of the CAA modified the calculation of the Medicaid portion of the hospital-specific DSH limit to include only costs and payments for services furnished to beneficiaries for whom Medicaid is the primary payer for such services, as specified in section 1923(g)(1)(B)(i) of the Act.[12] Accordingly, the limit generally excludes costs and payments for services provided to Medicaid beneficiaries with other sources of coverage, including Medicare and commercial insurance. Through previous rulemaking, we established, for the purpose of the hospital-specific DSH limit, how to determine whether third party coverage exists for a hospital service. In the December 3, 2014, **Federal Register**, CMS published the final rule entitled "Medicaid Program; Disproportionate Share Hospital Payments—Uninsured Definition"

[11] See discussion at pages 20-22 of the Coordination of Benefits and Third-Party Liability In Medicaid Handbook: 2020, available at: *https://www.medicaid.gov/sites/default/files/2020-08/COB-TPL-Handbook.pdf*.
[12] 88 FR 11865 at 11688.

(Uninsured Rule).[13] In that final rule, we indicated that we would apply a single, service-specific determination of third-party coverage status for an entire hospital service for purposes of hospital-specific DSH limit calculations.[14] While the Uninsured Rule focused on the determination of whether an individual is insured for a particular hospital service, the statutory changes made by section 203 of the CAA now call for a similar, single, service-specific determination to be made with respect to services provided to individuals with Medicaid coverage, to ascertain whether Medicaid is the primary payer for the service.

Before the statutory amendments made by section 203 of the CAA 2021, section 1923(g)(1)(A) of the Act included in the Medicaid shortfall portion of the hospital-specific DSH limit calculation costs and payments of individuals "eligible for medical assistance under the State plan." As discussed in the Uninsured Rule, costs and payments associated with the provision of inpatient and outpatient hospital services for all Medicaid eligible individuals would have been captured in the Medicaid shortfall portion of the calculation, regardless of whether that individual's Medicaid benefit was exhausted, or a Medicaid coverage limit had been reached for the associated inpatient or outpatient hospital service.[15] Similarly, due to the previous statutory language indicating that individuals need only to have Medicaid eligibility without regard to Medicaid coverage for the particular service, inpatient and outpatient hospital services for Medicaid eligible individuals should have been captured in the Medicaid shortfall, even where the individual's Medicaid benefits were limited and did not extend to inpatient or outpatient hospital services at all. Because the individual was eligible for some Medicaid coverage during the service period, the individual would have been included in the Medicaid shortfall portion of the hospital-specific DSH limit, not in the uninsured shortfall portion.

However, section 1923(g)(1)(B)(i) of the Act, as amended by section 203 of the CAA 2021, now specifies that the Medicaid shortfall portion of the hospital-specific DSH limit will be

[13] 79 FR 71679.
[14] 79 FR 71679 at 71683.
[15] 79 FR 71679 at 71682.

limited to costs and payments of furnishing hospital services to "[i]ndividuals who are eligible for medical assistance under the State plan or under a waiver of such plan and for whom the State plan or waiver is the primary pay[e]r for such services." We interpret the statutory change specifying that Medicaid must be the primary payer "for such services" to direct a service-specific approach to determining Medicaid's status as primary payer, consistent with how, under the Uninsured Rule, we determine an individual's status as uninsured for a particular hospital service.

Following the service-specific approach to determining an individual's insured status as outlined in the Uninsured Rule,[16] to similarly determine whether Medicaid is the primary payer for a given hospital service furnished to a Medicaid beneficiary, the beneficiary must have Medicaid coverage for the hospital service, and there must not be any third-party coverage that is primary for the particular hospital service, and Medicaid must be the primary payer for the service. When Medicaid is determined to not be the primary payer for that service, then the associated costs and payments for that specific hospital service would not be included in the calculation of the hospital-specific DSH limit (unless so provided for a qualifying hospital under the 97th percentile exception).

Comment: One commenter questioned whether Medicaid would be considered the primary payer or if a patient would be considered uninsured if the patient has some Medicaid coverage but does not have Medicaid coverage for the particular inpatient and outpatient hospital services.

Response: As discussed previously in this final rule, only costs and payments for inpatient and outpatient hospital services for which Medicaid is the primary payer under a single, service-specific determination can be included in the Medicaid shortfall portion of the hospital-specific DSH limit. Specifically, the statute now requires that Medicaid be the "primary pay[e]r for such services" (meaning "hospital services" as stated in section 1923(g)(1)(A)(i) of the Act)

[16] 79 FR 71679 at 71683.

furnished to an individual eligible under the Medicaid State plan or waiver, for costs and payments associated with the services to be included in the Medicaid shortfall portion of the hospital-specific DSH limit calculation. Medicaid would not be considered the primary payer for hospital services, for purposes of the calculation of the hospital-specific DSH limit, for an individual who had Medicaid coverage for inpatient and/or outpatient hospital services but had reached coverage limits or otherwise exhausted the Medicaid hospital benefit prior to obtaining these services. As a result, such an individual, as long as there is not third-party coverage for the inpatient and/or outpatient hospital services, would be considered uninsured for those hospital services and the associated costs and payments would be captured in the uninsured portion of the hospital-specific DSH limit calculation. Similarly, the costs and payments associated with the provision of hospital services provided to an individual with a limited Medicaid benefit package, which does not cover such inpatient and/or outpatient hospital services, would also be captured in the uninsured portion of the hospital-specific DSH limit calculation, provided they do not have third-party coverage for such services. Hospitals qualifying to meet the exception for 97th percentile hospitals would calculate the hospital-specific limit that is the higher value of that calculated under the methodology in which costs and payments for Medicaid patients are counted in the Medicaid shortfall calculation only for services furnished to beneficiaries for whom Medicaid is the primary payer, or the methodology in effect on January 1, 2020.

For purposes of the methodology in effect on January 1, 2020, costs and payments associated with the universe of Medicaid eligible individuals would be captured in the Medicaid portion of the hospital-specific DSH limit calculation regardless of whether or not the individual had Medicaid coverage for inpatient and/or outpatient hospital services and regardless of whether any such coverage had been exhausted. We note that while the change in policy as a result of the amendments made by section 203 of the CAA 2021 results in different treatment of some Medicaid eligible individuals for purposes of calculating hospital-specific DSH limits (based on whether the individual's Medicaid benefits include coverage of inpatient and/or outpatient

hospital services, and whether the individual's Medicaid benefits for hospital services have been exhausted or coverage limits have been reached), this change does not affect the costs and payments captured in hospital-specific DSH limit calculations overall, provided that the individual has no other health insurance or other source of third-party coverage for inpatient and/or outpatient hospital services, as relevant. Rather, the change merely affects whether particular costs and payments are captured in the Medicaid or uninsured shortfall portion of the hospital-specific DSH limit calculation.

Comment: Some commenters had specific questions regarding who is considered the primary payer in cases involving dually eligible individuals when coverage limits, whether through Medicare or private insurance, have been reached or have otherwise been exhausted. Commenters inquired about the scenarios when third-party coverage has reached its limit or is exhausted prior to an individual obtaining an inpatient or outpatient hospital service versus when the third-party insurer's coverage limit is reached, or coverage otherwise exhausted at some point during the provision of the service. One commenter questioned if Medicaid would be considered the primary payer for patients residing in an institution for mental diseases who are dually eligible for Medicare and Medicaid whose Medicare benefits are exhausted during the stay. Commenters questioned whether Medicaid actually has to pay on the claim for Medicaid to be considered the primary payer.

Response: As discussed in the Uninsured Rule, we determine whether an individual is insured for a particular service based on whether that individual has third party coverage for the single, specific inpatient hospital service, regardless of whether that individual was insured for the full service or service period or only a portion (for example, due to coverage limits being reached or coverage otherwise exhausted).[17] In the Uninsured Rule, we explained that the single, service-specific approach means, for the purpose of the hospital-specific DSH limit, third party coverage is determined for a given hospital stay, without separating the component parts of the

[17] 79 FR 71679 at 71683.

inpatient hospital services of that hospital stay. The single, service-specific approach also applies here to determine whether Medicaid is the primary payer for a particular hospital stay; we will look to whether there is third party coverage that pays primary over Medicaid for the inpatient hospital services of the stay. For example, if an individual has Medicare or private insurance that only provided coverage for the first 5 out of 10 days of a hospital inpatient stay (whether in a hospital that is an institution for mental diseases or not), Medicaid would not be considered the primary payer for any portion of that inpatient stay, even after the Medicare or private insurance coverage limit has been reached in the middle of the stay. However, if the dually eligible individual is either not insured for or has exhausted their Medicare or other third-party coverage prior to obtaining the inpatient or outpatient hospital service, Medicaid may be considered the primary payer for such services because there is no third-party coverage that pays primary over Medicaid for the particular stay. As we stated in the Uninsured Rule, services beyond health insurance coverage limits, including annual lifetime limits, will not be considered to be within a covered benefit package.[18] We note that real-life cases can be much more complex, and that States and providers should refer to existing third party liability rules and policies, such as section 1902(a)(25)(A) of the Act and §§ 433.135 through 433.154, when determining third-party liability, and to existing DSH rules and policies such as those described in the Uninsured Rule to determine how each case should be evaluated for third party coverage for the purpose of the hospital-specific DSH limit. Finally, as we stated in the Uninsured Rule, the determination of which payer is primary with respect to a single, specific hospital service is based on the existence of coverage and does not depend on the hospital receiving payment from a particular payer.[19]

Comment: Some commenters inquired about the treatment of third-party payments related to services provided to Medicaid eligible individuals. Some commenters wanted to know

[18] 79 FR 71679 at 71691.
[19] Id.

whether a claim associated with a Medicaid eligible individual should have third-party payments removed or if the entire claim should not be considered in the calculation of the hospital-specific DSH limit. One commenter requested that CMS provide an example of a third-party payment associated with services furnished to a beneficiary with Medicaid as primary payer.

Additionally, commenters inquired about cases where an individual had no Medicare Part A coverage but had certain charges covered and paid by Medicare Part B during an inpatient stay. Similarly, commenters also inquired if Medicaid would be considered the primary payer for an inpatient stay in cases where the individual has third-party coverage for ancillary services but no coverage for routine inpatient hospital services, inquiring whether the inpatient routine portion of the stay would be includable in the Medicaid shortfall calculation of the hospital-specific DSH limit. Commenters questioned whether the individuals in these scenarios would be considered to have third party coverage, be uninsured, or if Medicaid could be considered the primary payer for these inpatient hospital services.

Response: As discussed previously, based on section 1902(a)(25)(A) of the Act and §§ 433.135 through 433.154, Medicaid is generally the payer of last resort. In general, an individual who has third-party coverage for inpatient hospital services provided during a hospital stay, with very limited exceptions, would be considered to have third-party coverage that is primary over Medicaid for the inpatient hospital services. Under the single, service-specific determination, we do not separate out components of the inpatient hospital services furnished during a particular inpatient stay. As such, when it is determined that there is third-party coverage for inpatient hospital services that is primary over Medicaid for a particular inpatient stay, none of the inpatient hospital service costs and payments associated with this inpatient stay, including third-party payments, may be included in the Medicaid shortfall calculation of the hospital-specific DSH limit.

Under existing third-party liability rules, there are limited exceptions to the general rule that Medicaid is the payer of last resort, and these exceptions typically apply to federally

administered health programs. For a federally administered health program to be an exception to the general status of Medicaid as the payer of last resort, the statute creating the program must expressly state that it pays for a service after Medicaid, such as the Ryan White Fund under 42 U.S.C. 300ff *et seq*.[20] If those other programs that are exceptions to the general status of Medicaid as the payer of last resort do cover and make payment for the same inpatient hospital services that Medicaid is the primary payer for, then such payments from the other programs would be treated as cost offsets when the costs and payments of the inpatient hospital services are included in the calculation of the Medicaid shortfall. This is an example of third-party payments associated with services furnished to a beneficiary with Medicaid as the primary payer.

However, commenters also specifically inquired about unique circumstances where, in addition to Medicaid, a hospital inpatient has Medicare Part B only (that is, the patient is not also entitled to or enrolled in Medicare Part A, or has already exhausted their Medicare Part A benefits), which pays for limited services in certain circumstances for a beneficiary who is an inpatient, or has other third-party coverage that is only for ancillary services. In general, we consider ancillary services to be services provided by a hospital that are separate from routine services[21] such as room and board, nursing, and support services; ancillary services may include x-ray, drug, laboratory, or other services, associated with an inpatient hospital stay.[22]

Regardless of whether the ancillary services are covered by Medicare Part B or another third-party payer, such as a private insurance policy, we will defer to States to determine whether

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[20] See, for example, 42 U.S.C. 300ff-15(a)(6), 42 U.S.C. 300ff-27(b)(7)(F), 42 U.S.C. 300ff-64(f), 42 U.S.C. 300ff-71(i). See also discussion at pages 20-22 of the Coordination of Benefits and Third-Party Liability In Medicaid Handbook: 2020, available at *https://www.medicaid.gov/sites/default/files/2020-08/COB-TPL-Handbook.pdf.*

[21] The Medicare Provider Reimbursement Manual, Part I, Section 2202.6 defines "routine services" as, "Inpatient routine services in a hospital or skilled nursing facility generally are those services included in by the provider in a daily service charge--sometimes referred to as the "room and board" charge. Routine services are composed of two board components: (l) general routine services, and (2) special care units (SCU's), including coronary care units (CCU's) and intensive care Units (ICU's). Included in routine services are the regular room, dietary and nursing services, minor medical and surgical supplies, medical social services, psychiatric social services, and the use of certain equipment and facilities for which a separate charge is not customarily made."

[22] The Medicare Provider Reimbursement Manual, Part I, Section 2202.8 defines ancillary services as, "Ancillary services in a hospital or SNF include laboratory, radiology, drugs, delivery room (including maternity labor room), operating room (including postanesthesia and postoperative recovery rooms), and therapy services (physical, speech, occupational). Ancillary services may also include other special items and services for which charges are customarily made in addition to a routine service charge."

that third-party coverage is considered coverage for inpatient hospital services. The Medicare program generally is structured to pay for inpatient hospital services under Part A, *see* section 1812(a)(1) of the Act, whereas Part B generally pays for specified services other than inpatient hospital services, *see* section 1832 of the Act. Given this structure, even where a beneficiary with Medicaid and Medicare Part B only coverage has payment made on their behalf by Part B for ancillary services that fall within the State's Medicaid definition of inpatient hospital services during an inpatient hospital stay, we believe that the State reasonably could determine that Medicaid – not Medicare Part B – will be considered to be the primary payer for the inpatient hospital stay. This approach would avoid a potentially anomalous outcome where Medicaid would pay for the majority of services, but a small Medicare Part B payment for an ancillary service would result in the exclusion of all costs and payments for the stay from the hospital-specific DSH limit.

Regarding the comment inquiring about other third-party coverage that only pays for ancillary services but not routine services, we do not have enough information about who this payer would be or what it would cover to give guidance on whether that third-party coverage would be regarded as coverage for inpatient hospital services and therefore would be considered primary to Medicaid. Again, in this case, we will defer to the State to make a reasonable determination of whether such third-party coverage provides coverage for inpatient hospital services that will be considered to be the primary payer for the inpatient hospital stay.

In this scenario, whether the payer in addition to Medicaid is Medicare Part B or another third-party payer, we further note that since individuals have coverage for inpatient hospital services (whether Medicaid, Medicare, or another third party), they would not be considered uninsured for purposes of inclusion in the hospital-specific DSH limit. As mentioned, we acknowledge that, where a State does determine that Medicare Part B or another third-party payer is the primary payer for inpatient hospital services where it only makes payments for ancillary services furnished during the stay, the inpatient hospital service costs and payments for

the entire inpatient stay would be excluded from the hospital-specific DSH limit, and this could result in the exclusion of some Medicaid costs and payments. We will monitor for State handling of these scenarios once the rule is in effect to ascertain whether the rule is resulting in unexpected outcomes, and we may undertake additional rulemaking in the future if necessary to address the issue.

Comment: One commenter inquired about the 2008 DSH audit final rule and associated protocol's instructions to use MMIS paid claims data. The commenter questioned whether States now will be required to change their MMIS systems to provide reports that remove the Medicaid "no-pays" for the DSH audits where there is a third-party payer.

Response: For any State plan rate year beginning or after October 1, 2021, States and hospitals must have procedures in place to ensure the Medicaid data used in the hospital-specific DSH limit calculation complies with the amendments made by section 203 of the CAA 2021 by determining when Medicaid is the primary payer for inpatient and outpatient hospital services. While the General DSH Audit and Reporting Protocol released with the 2008 DSH audit final rule does call for MMIS to be the source of Medicaid fee for service utilization and payment data, CMS is not specifically requiring any changes to MMIS to implement the amendments made by section 203 of the CAA 2021 or the provisions of this final rule. We generally would expect States' current MMIS would have the ability to support compliance with the requirements. However, States with legacy systems may require some configuration changes. For States that require MMIS system changes, CMS is available to work with them. To the extent that MMIS data on its own is not sufficient to identify Medicaid data needed to calculate the hospital-specific DSH limit, States are able to supplement MMIS data with other auditable data.

Comment: One commenter inquired about provisions of the February 28, 2023, proposed rule entitled "Medicare Program; Medicare Disproportionate Share Hospital (DSH) Payments: Counting Certain Days Associated With Section 1115 Demonstrations in the Medicaid Fraction"

(88 FR 12623). The commenter referenced statements by CMS indicating that section 1115 demonstration waivers that provide health insurance or premium coverage for inpatient hospital services will be included in Medicaid days for Medicare DSH calculations. As such, the commenter questioned if CMS considers coverage provided under these section 1115 demonstrations for inclusion in the Medicaid hospital-specific DSH limit calculations.

*Response***:** We note the Medicare DSH program and the Medicaid DSH program are separate programs authorized by different sections of the statute and with different purposes and goals. However, as stated in the February 2023 proposed rule, which appeared in the February 24, 2023, **Federal Register** (88 FR 11865) if an individual receives health insurance for inpatient hospital care directly provided by a section 1115 demonstration, or if a patient buys insurance for inpatient hospital care with premium assistance provided by a section 1115 demonstration for which the demonstration pays 100 percent of the premium cost to the individual, and in either case the cost of the insurance or premium assistance is paid for with title XIX dollars, the individual is regarded as eligible for Medicaid under the Medicare DSH statute. Similarly, this individual would be considered a Medicaid eligible individual for Medicaid DSH purposes. As such, costs and payments associated with covered inpatient and outpatient hospital services provided to this individual may be considered in the calculation of the hospital-specific DSH limit, depending on the determination of primary payer status and the provisions of section 1923(g) of the Act.

*Comment***:** Two commenters expressed support of our proposal of the October 1, 2021, effective date of the amendments to section 1923(g) of the Act made by section 203 of the CAA 2021, to be applicable for SPRYs beginning on or after the October 1, 2021, effective date. One commenter stated that the plain language of the law indicated that the effective date should apply to services furnished on or after October 1, 2021. One commenter requested that CMS confirm whether the application of the amendments to section 1923(g) of the Act made by section 203 of the CAA 2021 will apply on the basis of the Federal fiscal year or the SPRY. The commenter

also urged CMS to allow an effective date prior to October 1, 2021, by applying the statutory changes to cost reporting periods beginning on or before the October 1, 2021, date and rebasing DSH using FY 2021 cost reports. This commenter stated that this application would allow for a consistent way to gauge how hospital systems benefited from the DSH program. The commenter also indicated that CMS should be cognizant of the difference in State-to-State distribution of DSH funds.

*Response***:** We appreciate the commenters' support of our effective date proposal and disagree with the other commenter that our interpretation conflicts with the plain language of the statute. To align the statutory amendments made by section 203 of the CAA 2021 with how the Medicaid DSH program has been historically operationalized across States, we proposed to interpret the October 1, 2021, effective date to apply the statutory changes to SPRYs beginning on or after October 1, 2021. As discussed in the proposed rule and earlier in this final rule, this is consistent with past interpretations of statutory provisions that have been codified in rulemaking, such as in the 2008 DSH final rule, and further explained in sub-regulatory guidance. Moreover, CMS does not have the statutory authority to apply the effective date of the amendments made by section 203 of the CAA 2021 to periods before October 1, 2021. These provisions do not "rebase" DSH payments, per se, but rather change the definition of the hospital-specific limit for DSH payments.

We do not agree with the comment that changing the effective date to coincide with hospitals' cost reporting periods would provide a consistent view of how each hospital system benefits from DSH. We acknowledge that hospital cost reports, and internal audits of such cost reports, may not align with the State's SPRY. However, the DSH independent certified audit requirement at section 1923(j) of the Act, as implemented in the 2008 DSH final audit rule, requires States to conduct an audit of their DSH programs and identify DSH payments made against hospital-specific DSH limits on the basis of each State's SPRY.[23] As we indicated in the

[23] 42 CFR 455.304(d)(2).

proposed rule, this was in "recognition of varying fiscal periods between hospitals and States" and that "[t]he Medicaid [SPRY] is the period which each State has elected to use for purposes of DSH payments and other payments made in reference to annual limits."[24] We believe that the DSH independent certified audit, which within each State looks at all hospitals' uncompensated care costs and DSH payments based on that State's SPRY, provide for a consistent way to gauge how hospitals that receive DSH payments benefit from the DSH program.

Further, we believe interpreting this provision to be applicable on a FFY basis would impose an excessive burden on States and hospitals, in particular with the application of the exception for 97th percentile hospitals. We note that the majority of States have SPRYs that do not align with the FFY. In these instances, if we were to apply section 203 of the CAA 2021 to the FFY beginning on October 1, 2021, and thereafter, States would need to prorate the uncompensated care costs for affected hospitals within a SPRY accordingly, since the methodology for calculating the Medicaid shortfall portion of the hospital-specific DSH limit may not be consistent for the entire SPRY. If the hospital qualified as a 97th percentile hospital for only a portion of the SPRY, this proration would be on top of the proration that would already be necessary to account for differences between a hospital's cost reporting period and the State's SPRY.

Finally, we believe the commenter who requested that we be cognizant of the difference in State-to-State distribution of DSH funds was pointing out that each State operates its DSH program differently, and that there is variation in how States distribute their DSH payments to eligible providers within their State DSH allotments. We acknowledge that States have flexibility in the operation of their DSH programs, subject to Federal requirements, including section 1923(g) of the Act on the hospital-specific DSH limit. This final rule does not affect the existing flexibility each State has in how it operates its DSH program or distributes its DSH payment in accordance with its State plan, but this rule does address the changes to the hospital-

[24] 88 FR 11865 at 11870.

specific DSH limit as required by section 203 of the CAA. We also acknowledge that while the statutory changes to the hospital-specific DSH limit are applicable to all States, the actual impact on hospitals can vary by States based on how DSH payments are distributed by each State. In developing this rule, we considered that each State operates its own DSH program. For example, we considered proposing to determine the 97th percentile hospital exception qualification on a State-specific level, rather than on a national level; however, as we explained in the proposed rule, we do not believe this would be consistent with the statutory language referring to "97th percentile of all hospitals." Applying section 1923(g) of the Act, as amended, on a SPRY basis is aligned with how States operate their DSH programs and distribute their DSH funds, which are on a State-elected SPRY basis. As such, we are finalizing this requirement to apply the October 1, 2021, effective date to the applicable SPRY beginning on or after October 1, 2021, as proposed.

Comment: One commenter indicated that CMS should provide guidance on a SPRY audit year that includes the October 1, 2021, effective date, and direction on how hospital-specific DSH limits and associated overpayments should be calculated.

Response: As indicated previously in this final rule, we are finalizing this rule to apply the October 1, 2021, effective date to the applicable SPRY beginning on or after the October 1, 2021, effective date. To calculate hospital-specific DSH limits, hospitals routinely utilize two separate cost reports to cover the entire period associated with the applicable SPRY, in cases where the hospital's cost reporting period does not correspond exactly to the SPRY. We have released guidance to answer specific questions related to addressing these misaligned periods.[25]

In the Additional Information on DSH Reporting and Auditing Requirement Part 2 - Question 21, we discussed cost report proration in calculating a hospital's uncompensated care costs (UCC) for a SPRY using more than one cost report, when a hospital's cost reporting period

[25] *https://www.medicaid.gov/sites/default/files/2020-01/part-2-additional-info-on-dsh-reporting-and-auditing.pdf*.

does not align with the State's SPRY.[26] Similar proration was discussed when applying the "DSH Payments—Treatment of Third-Party Payers in Calculating Uncompensated Care Costs" final rule (82 FR 16114) in the August 18, 2020, CMCS Informational Bulletin entitled "Treatment of Third Party Payers (TPP) in Calculating Uncompensated Care Costs (UCC)."[27]

We expect that activities required for the implementation of the amendments made by section 203 of the CAA 2021 to follow the same proration approach to conform hospitals' cost reporting periods to the SPRY. For example, if a SPRY is from July 1, 2022 to June 30, 2023, and a hospital's cost report year end is December 31, regardless of the amendments made by section 203 of the CAA 2021, there is a need to prorate the hospital's cost report data from both its December 31, 2022 and December 31, 2023 cost reports to determine the hospital's hospital-specific DSH limit for the SPRY from July 1, 2022 to June 30, 2023. In using the December 31, 2022, and December 31, 2023, cost report data to prorate to this SPRY, which is the State's first SPRY that begins on or after October 1, 2021, the hospital and the State would need to follow section 1923(g) of the Act, as amended by section 203 of the CAA 2021, and this final rule in determining the hospital-specific limit. As is consistent with 2008 DSH audit final rule, an overpayment is identified when the DSH payment received by a hospital for the SPRY is in excess of its hospital-specific limit for the same SPRY.

Comment: Several commenters expressed support of our proposal to determine a hospital's qualification for the 97th percentile exception for each SPRY on a prospective basis.

Response: We appreciate the support and are finalizing the determination of a hospital's qualification for the 97th percentile exception for each SPRY on a prospective basis. This application allows for States and hospitals to know prior to the beginning of the SPRY which hospitals qualify for the exception. This allows States and hospitals to gauge how payments

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[26] Id.

[27] *https://www.medicaid.gov/sites/default/files/2020-08/cib081820.pdf.*

should be made and measured against hospital-specific DSH limits and provides greater payment predictability than a retroactive application.

Comment: One commenter expressed support for the proposal that CMS would produce two lists for qualifying hospitals to meet the exception for 97th percentile hospitals, based on either the percentage or total number of inpatient days for patients who were entitled to both Medicare Part A benefits and SSI benefits. One commenter commended CMS for determining the number of Medicare Part A SSI days for the most recent cost reporting period based on the days associated with discharges occurring during the cost reporting period.

Response: We appreciate the support. We have followed the statutory language at section 1923(g)(2)(B)(i) and (ii) of the Act that specifies that hospitals may qualify on the basis of total number of inpatient days for patients who were entitled to both Medicare Part A benefits and SSI benefits or the percentage of such days. Further, we appreciate the support for our proposal to determine the number of Medicare Part A SSI days for the most recent cost reporting period based on the days associated with discharges occurring during the cost reporting period and are finalizing the methodology as proposed.

Comment: Several commenters urged CMS to release the 97th percentile exception lists, including those applicable to SPRY 2022, as soon as possible. Several hospital associations and hospitals expressed that delays in the release may impact their ability to plan for future DSH payments with respect to anticipated decreased hospital-specific DSH limits. Two commenters recommended that CMS release the 97th percentile exception lists at least 60 days prior to the October 1 date to which the exception lists will apply. Another commenter indicated that releasing the list at least 60 days prior to the October 1 date would allow the State and hospitals sufficient time to work within the time frames established in the State laws that govern how interim DSH payments are calculated and made to providers to make any necessary adjustments to DSH payments based on the 97th percentile exception lists.

Response: We understand the commenters' concerns. Unfortunately, we cannot commit to publishing the 97th percentile exception lists at least 60 days prior to the October 1 date to which the exception lists will apply. Given the dates that the necessary data become available, and the time needed for CMS to produce and publish the 97th percentile hospital exception qualification lists, we cannot be certain of our ability to meet this deadline. However, we are committed to releasing the exception lists as soon as possible, after March 31 of each year, in advance of the October 1 date. Due to the timing of this final rule, we will be releasing the exception lists retroactively for the first three years (that is, for SPRYs beginning on or after October 1, 2021, to September 30, 2024). For SPRYs beginning on or after October 1, 2024, we will follow the established timeline so that States and hospitals will have the exception lists prior to October 1 each year, followed by a correction list if needed, as discussed earlier in this final rule.

Comment: Many commenters requested that CMS release the rankings and associated data for all hospitals in the universe of providers used to determine the qualification for the exemption for 97th percentile hospitals, rather than just those hospitals that qualify for the exemption. Commenters indicated that this would provide for greater transparency and also be informative to hospitals so that they know where they stand in the rankings. One commenter inquired whether CMS would release the underlying data used in compiling the 97th percentile hospital exception lists to allow for validation of CMS's calculations. One commenter indicated that the qualifying lists should be readily accessible for use by State Medicaid agencies, hospitals, and other interested parties.

Response: We intend to make available the data necessary for CMS to calculate the rankings of hospitals in the dataset. This data may include hospital names, Medicare provider numbers, cost report record numbers, cost reporting period, cost report status, SSI/Part A days, and total inpatient days for each hospital and its distinct part psychiatric and rehabilitation units, if applicable, in this universe of data. We will publish these data on an annual basis,

electronically or in another format as determined by CMS, prior to the SPRY to which the associated 97th percentile hospital exception lists will apply.

Comment: Several commenters pointed to the "all hospital" language in section 203 of the CAA 2021 and opposed CMS' proposal to exclude hospitals that do not file Medicare cost reports from the dataset used to determine which hospitals meet the exception for 97th percentile hospitals. Commenters indicated that this omission would result in fewer hospitals qualifying to meet the 97th percentile exception by merit of shrinking the pool of hospitals in the dataset. Commenters requested that CMS include these hospitals in the datasets using zero values in the calculations. Commenters indicated that requiring the submission of the Medicare cost report to determine qualification to meet the exception for 97th percentile hospitals would be burdensome, urging CMS to consider less administratively burdensome alternatives.

Response: We understand and appreciate the commenters' concerns. We have worked to identify and include as many hospitals as possible in the list of hospitals used to determine the 97th percentile hospital exception. While we understand that the statute refers to hospitals that are "in at least the 97th percentile of all hospitals" and that not all hospitals submit a Medicare cost report, the statute directs us to make the 97th percentile exception qualification determination based on each hospital's "most recent cost reporting period." We continue to believe it is reasonable to interpret "all hospitals" in this context to mean all hospitals with cost reports and to look to HCRIS, an existing CMS cost report data source, to identify a hospital's "most recent cost reporting period" for which a hospital has a cost report. We are not imposing any additional cost reporting requirements on hospitals for the purpose of implementing the 97th percentile hospital exception. Furthermore, we believe it is reasonable and appropriate to use these data to build the hospital dataset and obtain each hospital's total inpatient days, and to establish a cutoff for how far back we would look within the HCRIS database to reduce the inclusion of terminated, inactive hospitals. We again note that we proposed to include any hospital that has in HCRIS a cost report with an end date dating back to at least September 30, 3

years prior to the snapshot date we are using to extract data. For example, for the 97th percentile qualification for SPRYs beginning during FFY 2024, the snapshot date is March 31, 2023, and we would include any hospital that has in HCRIS a cost report with a cost reporting period end date of September 30, 2020, or later.

We selected the 3-year cutoff based on timing of cost report submissions but also considering cost report filing delays and HCRIS processing lags. As long as a hospital has a cost report in the HCRIS database that meets the criteria on March 31, the snapshot date we are establishing to allow us to timely generate the 97th percentile hospital exception lists each year, the hospital will be included in the dataset. We are also including Medicare cost reports that are filed as low- or no-Medicare utilization cost reports as long as they exist in the HCRIS database and meet the specified timing criteria. Where there is no total inpatient day information or the total patient day is reported as zero in a cost report included in our dataset, we will use a zero value for the percentage of total inpatient days that are Medicare Part A SSI days for the purpose of the 97th percentile hospital ranking.

As discussed in the proposed rule, even if we were to consider an alternative mechanism outside of the existing Medicare cost report data to collect total inpatient days from hospitals without Medicare cost reports in HCRIS, there would not be a way to define the most recent cost reporting period for those hospitals that would be consistent with how we are defining it for hospitals that do have a cost report. As such, we are finalizing the rule as proposed to exclude hospitals with no Medicare cost report from the dataset we will use to determine the lists of hospitals qualifying for the exception for 97th percentile hospitals.

Comment: One commenter expressed support for the March 31 HCRIS snapshot date. The commenter indicated this will provide CMS proper time to ensure validity and uniformity of the database.

Response: We agree; we thank the commenter for their support and are finalizing as proposed.

Comment: A commenter indicated that under certain circumstances, there could be multiple hospitals that file under a single Medicare cost report and provider number. The commenter questioned if a Medicare hospital provider number qualified to meet the 97th percentile exception, would all hospitals associated with that provider number qualify to meet the 97th percentile exception.

Response: Yes, this would qualify all hospitals under this CMS Certification Number (CCN) to meet the exception for 97th percentile hospitals. Our 97th percentile hospital exception determination uses each Medicare-participating hospital's cost report and the inpatient days for the relevant cost reporting period, all associated with the hospital's CCN as stated on the cost report and inclusive of the CCN of any psychiatric and/or rehabilitation distinct parts that provide hospital services. Therefore, the 97th percentile hospital exception qualification would apply to the Medicare-participating hospital as a whole. If there are circumstances where a State Medicaid agency recognizes a Medicare-participating hospital, identified on our 97th percentile hospital list as a single hospital, as multiple hospitals, then the 97th percentile exception hospital qualification of the single Medicare-participating hospital would apply to those multiple hospitals recognized under Medicaid.

Comment: One commenter indicated support for broadening the 97th percentile exception to a universe that includes all hospitals, despite initially believing that the exception applied only to inpatient prospective payment system (IPPS) hospitals.

Response: We appreciate the support. We recognize that not only IPPS hospitals receive Medicaid DSH payments, but critical access, rehabilitation, and psychiatric hospitals also may qualify to receive DSH payments. Further, section 1923(g)(2)(B) of the Act, as amended by section 203 of the CAA 2021 statute specifies that a hospital must be in "at least the 97th percentile of all hospitals" to qualify to meet the exception. As such, we will produce the qualification lists inclusive of all hospital types and all hospitals with a Medicare cost report in HCRIS that satisfies the timing criteria discussed earlier in this final rule.

Comment: One commenter was supportive of CMS' proposal to allow hospitals to identify data issues resulting from mathematical or other similar technical errors. However, the commenter noted that the 1-year period may not be sufficient, particularly given the retroactive application of the initial datasets. Further, the commenter insisted that the identification of issues should not be limited to mathematical or other similar technical errors.

Response: We appreciate the support but disagree with the need to extend the 1-year period to identify issues resulting from mathematical or other similar technical errors. In addition, we disagree that the scope should be broader than issues resulting from mathematical or other similar technical errors. Any dispute over the underlying Medicare cost report and claims data is outside of this process. We will not attempt to resolve disputes on Medicare cost report and claims data, nor amend the underlying cost report and claims data as they existed in the database, as of the snapshot date.

The process and procedures that we are establishing for the 97th percentile hospital exception relies on existing Medicare data in the CMS cost report and claims systems as of a particular snapshot date each year. We will ensure that we are extracting the correct values from those systems and compiling them accurately in accordance with the procedures we are establishing in this final rule and proposed to allow for an opportunity to make corrections where mathematical or other similar technical errors may occur in these steps. As such, we proposed to give States and interested parties 1 year from the release of the 97th percentile hospital lists and dataset, including those for retroactive periods back to the first SPRYs beginning on or after October 1, 2021, to bring forward issues resulting from mathematical or other similar technical errors made by CMS in the steps of extracting and compiling the data and determining the 97th percentile hospital exception qualification. We believe that not only is this timeframe appropriate for addressing the narrow scope of errors we would expect could arise in this process but also extending the timeframe out further would extend the period of uncertainty for States and hospitals relying on timely, finalized data.

Comment: One commenter requested that in instances where CMS issues a revised qualifying list, any hospital that qualified to meet the exception for 97th percentile hospitals on the initial list should retain that status regardless of its ranking on the revised list. The commenter indicated that this policy would mitigate any financial disruption to hospitals.

Response: We understand the commenter's concern. However, in the unlikely case that an initially qualified hospital would fall below the 97th percentile threshold upon issuance of a corrected list of qualifying hospitals, that hospital would not qualify to meet the exception for 97th percentile hospitals. The statutory language at section 1923(g)(2)(B) of the Act is clear that to qualify to meet the exception, the hospital must be in at least the 97th percentile of all hospitals for the most recent cost reporting period with respect to the total number of inpatient days for the period that were made up of patients entitled to Medicare Part A and SSI benefits, or the percentage of total inpatient days made up of such days. As such, we have no authority to allow an unqualified hospital to receive the 97th percentile hospital exception due to a mathematical or other similar technical error that resulted in its erroneous inclusion on an initial list of qualifying hospitals. We are finalizing all aspects of the error correction process as proposed.

D. Limitations on Aggregate Payments for DSHs Beginning October 1, 1992 (§ 447.297)

We proposed to eliminate the § 447.297(c) requirement to publish annual DSH allotments in the **Federal Register** and to provide that the Secretary would post preliminary and final national expenditure targets and State DSH allotments in the Medicaid Budget and Expenditure System/State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) and at Medicaid.gov (or similar successor system or website). Current regulations require us to publish the annual DSH allotments in the **Federal Register**. We have found this process to be time consuming and administratively burdensome for us and are concerned that it makes providing the information to States and other interested parties less timely and accessible. Additionally, because we currently notify States directly regarding annual

allotment amounts and make such information publicly available outside of the **Federal Register** on a routine basis**,** we find that it is duplicative and unnecessary to go through the process of publishing in the **Federal Register**. Therefore, by eliminating the § 447.297(c) requirement to publish annual DSH allotments in the **Federal Register**, we explained that we would be removing the administratively burdensome task, which would allow us to focus our efforts on providing the information in a timely and easily accessible manner through the MBES/CBES and at Medicaid.gov (or similar successor system or website).

Additionally, we proposed in § 447.297(b) and (d)(1) to remove the date on which final national targets and allotments are published, currently specified as April 1, and revise this timeframe to as soon as practicable. In § 447.297(d)(1), we also proposed to remove the phrase "prior to the April 1 publication date," and to add in its place the phrase, "prior to the posting date" for consistency with the new timeframe. We proposed to remove the April 1 publication date to allow for Medicaid expenditures associated with the FFY DSH allotment to be finalized. CMS utilizes these amounts in the calculations of the 12 percent limit under section 1923(f)(3)(B)(ii) of the Act. Finally, we proposed to remove § 447.297(c), which consists of redundant publication requirements already identified in § 447.297(b), (c), and (d), in its entirety, to align with our proposed changes § 447.297(c).

We received public comments on these proposals. The following is a summary of the public comments we received and our responses.

Comment: Several commenters commented on this proposal, and with one exception, commenters were not supportive of this proposal. The commenters cited concerns about transparency, as the MBES/CBES systems where we would publish amounts are not accessible to the general public. They also cited concerns about accountability, as Medicaid.gov is less formal than a **Federal Register** publication, and the latter ensures a static record for historicity.

Response: While we appreciate the concerns of commenters, we are finalizing as proposed. We will ensure ongoing transparency by publishing final amounts on a publicly

accessible page on Medicaid.gov instead of simply distributing to States through MBES/CBES. This step ensures that hospitals, researchers, oversight entities, and others will have timely access to the data as well. We also believe posting to Medicaid.gov can provide sufficient accountability regarding the accuracy of the final amounts. We already publish many important documents and guidance on our website, and we will ensure the postings are clear with respect to the date they are published, and with versions for any necessary changes.

Comment: A couple commenters specifically opposed the removal of the "April 1" date from the regulatory language and did not want the final allotments published any later than that date.

Response: We are also finalizing as proposed the regulatory language removing the "April 1" date specification and replacing it with "as soon as practical." Our reasoning is twofold. First, we already currently send States information prior to when the **Federal Register** publication occurs. This change will not alter our existing practice of providing information to States as soon as we have it available. Second, this change is important to allow us flexibility when some States are late reporting their expenditure data, causing a delay in calculating final allotments. By removing the April 1 language, we can ensure that the publicly available final report is more accurate.

We acknowledge this change in publication location and uncertainty of dates could make it difficult for non-State entities to know when the final allocation report is available. We intend to communicate through multiple channels, such as emails, list servs, and calls with interested parties, when the Medicaid.gov publication will be available, and once it is posted.

E. Reporting Requirements (§ 447.299)

1. Calculating Medicaid Shortfall

We proposed to revise § 447.299(c)(6), (7), (10), and (16) to reflect the statutory changes made by section 203 of the CAA 2021 to update the methodology for calculating the Medicaid shortfall portion (Medicaid costs less Medicaid payments) of the hospital-specific DSH limit to

only include costs and payments for hospital services furnished to beneficiaries for whom Medicaid is the primary payer, effective for the SPRY beginning on or after October 1, 2021, and subsequent years, and to include the statutory exception for 97th percentile hospitals. Hospitals meeting this exception will calculate their hospital-specific DSH limit using the higher value of either the hospital-specific DSH limit calculated per the methodology which includes only costs and payments associated with beneficiaries for whom Medicaid is the primary payer or the hospital-specific DSH limit calculated per the methodology in effect on January 1, 2020. We reviewed the other data elements in § 447.299(c) to determine if additional updates were necessary to account for the changes made by section 203 of the CAA 2021. However, we noted our belief that these are the only data elements requiring updates because these are the only elements that will differ based on whether statutory requirements provide for the consideration of all Medicaid eligible individuals or only those for whom Medicaid is the primary payer. Therefore, we explained that it was only necessary to revise § 447.299(c)(6), (7), (10), and (16) to account for the statutory changes made by section 203 of the CAA 2021.

Accordingly, we proposed to revise § 447.299(c)(6), which specifies that this data element should include inpatient and outpatient Medicaid fee-for-service (FFS) basic rate payments paid to hospitals, "not including DSH payments or supplemental/enhanced Medicaid payments, for inpatient and outpatient services furnished to Medicaid eligible individuals." We proposed this change because, for most hospitals, for SPRYs beginning on or after October 1, 2021, only those FFS payments for Medicaid eligible individuals for whom Medicaid is the primary payer will be counted in the calculation of the hospital-specific DSH limit. Therefore, we proposed to revise § 447.299(c)(6) to remove the reference to Medicaid eligible individuals and update the regulatory text to indicate that FFS payments for inpatient and outpatient hospital services furnished to Medicaid individuals in accordance with § 447.295(d) should be included in this data element.

We also proposed to revise § 447.299(c)(7), which specifies that this data element includes payments made to the hospitals "by Medicaid managed care organizations for inpatient hospital and outpatient hospital services furnished to Medicaid eligible individuals." We proposed this change because for most hospitals, for SPRYs beginning on or after October 1, 2021, only payments made by Medicaid managed care organizations for Medicaid eligible individuals for whom Medicaid is the primary payer will be counted in the calculation of the hospital-specific DSH limit. Therefore, we proposed to revise § 447.299(c)(7) to remove the reference to Medicaid eligible individuals and update the regulatory text to indicate that Medicaid managed care payments for inpatient and outpatient hospital services furnished to Medicaid individuals in accordance with § 447.295(d) should be included in this data element.

We also proposed to revise § 447.299(c)(10), which specifies that this data element includes "costs incurred by each hospital for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individuals." We proposed this change because for most hospitals, for SPRYs beginning on or after October 1, 2021, only costs incurred on behalf of Medicaid eligible individuals for whom Medicaid is the primary payer will be counted in the calculation of the hospital-specific DSH limit. Therefore, we proposed to revise § 447.299(c)(10) to remove the reference to Medicaid eligible individuals and update the regulatory text to indicate that costs incurred by each hospital for furnishing inpatient hospital and outpatient hospital services to Medicaid individuals as determined in accordance with § 447.295(d) should be included in this data element.

Finally, we proposed to revise § 447.299(c)(16), which currently specifies the calculation of uncompensated care costs to include "the total cost of care for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individuals" and the uninsured, which are to be offset by "Medicaid FFS rate payments, Medicaid managed care organization payments, supplemental/enhanced Medicaid payments, uninsured revenues, and section 1011 payments for inpatient and outpatient hospital services." Therefore, we proposed to revise § 447.299(c)(16) to

remove the reference to "Medicaid eligible individuals" and update the regulatory text to indicate that total annual uncompensated care cost equals the total cost of care for furnishing inpatient hospital and outpatient hospital services to "Medicaid individuals as determined in accordance with § 447.295(d) and to individuals with no source of third-party coverage for the hospital services they receive," less the sum of payments received on their behalf, should be included in this data element.

We proposed that this and other CAA 2021-related proposals, noted in the respective sections, be applicable to fiscal years beginning on or after October 1, 2021, to align with the effective date of the amendments made by section 203 of the CAA 2021.

We received public comments on these proposals. The following is a summary of the public comments we received and our responses.

Comment: A few commenters indicated that the DSH audit should indicate which hospitals met the exception for 97th percentile hospitals and which methodology had a higher hospital-specific DSH limit: the limit including only costs and payments for Medicaid patients for whom Medicaid is the primary payer in the Medicaid portion of the hospital-specific limit calculation, or the methodology in effect on January 1, 2020. Commenters indicated that this information would be beneficial for informing future policy decisions.

Response: We agree that this would be useful information and suggest that auditors provide this information in the independent certified audit. Because we did not propose to include this element as a required part of the independent certified audit, future rulemaking would be necessary to impose this as a requirement. We are finalizing the provisions as proposed.

2. Reporting DSH overpayments

To improve the accuracy of identification of provider overpayments discovered through the DSH audit process, we proposed to add an additional reporting requirement for annual DSH audit reporting required by § 447.299. We proposed to redesignate § 447.299(c)(21) as

paragraph (c)(22) of that section, and to add a proposed new § 447.299(c)(21) to require an additional data element for the required annual DSH audit reporting. The new data element we proposed would require auditors to quantify the financial impact of any finding, including any impact resulting from incomplete or missing data, lack of documentation, non-compliance with Federal statutes or regulations, or other deficiencies identified in the independent certified audit, which may affect whether each hospital has received DSH payments for which it is eligible within its hospital-specific DSH limit.

Currently, audits may include a caveat indicating the auditors are unable to quantify the financial impact of an identified audit finding. We proposed that, for purposes of § 447.299, audit finding means an issue identified in the independent certified audit required under § 455.304 concerning the methodology for computing the hospital-specific DSH limit or the DSH payments made to the hospital, including compliance with the hospital-specific DSH limit as defined in § 447.299(c)(16). For example, an audit may identify that a hospital was unable to satisfactorily document the outpatient services it provided to Medicaid eligible patients, resulting in the exclusion of associated costs and payments from the Medicaid shortfall calculation. Based on this lack of documentation, the audit may include a caveat noting the auditor's finding that the hospital's total uncompensated care cost may be misstated as a result of this exclusion, with unknown impact on the hospital-specific DSH limit. Given this lack of quantification of the financial impact of this finding, CMS and the State would be unable to determine whether an overpayment has resulted related to this audit finding, and if so, the amount. We believe that requiring the quantification of such findings would limit the burden on States and CMS of performing follow-up reviews or audits. Specifically, conducting a secondary review or audit after the independent auditors have completed theirs would lengthen the review process, and therefore, delay the results of the audit. It would also require additional time, personnel, and resources by CMS, States, and hospitals to participate in a secondary review or audit, which would largely duplicate aspects of the audit already conducted by the independent auditor. If

finalized, the new data element would help ensure appropriate recovery and redistribution, as applicable, of all DSH overpayments in excess of the hospital-specific limit. Adding this requirement to the submission would also ensure auditors provide the additional information at the time they are already reviewing the applicable data, reducing the labor burden as opposed to a later, secondary audit.

We explained that auditors would be afforded the professional discretion and the flexibility to determine how to best quantify these amounts in the audit findings. For example, auditors would be able to use alternative source documentation, utilize a methodology to estimate the financial impact in terms of the dollar amount at risk, or provide an estimated range of financial impact if a determination of an exact dollar amount is not possible. However, we also noted our understanding that, due to the complexity of issues that may arise, the actual financial impact of an audit finding may not always be calculable. Therefore, we proposed that, in the expectedly rare event that the actual financial impact cannot be calculated, a statement of the estimated financial impact for each audit finding identified in the independent certified audit that is not reflected in the other data elements identified in § 447.299(c) would be required. We proposed that actual financial impact would mean the total amount associated with audit findings calculated using the documentation sources identified in § 455.304(c). Estimated financial impact would mean the total amount associated with audit findings calculated on the basis of the most reliable available information to quantify the amount of an audit finding in circumstances where complete and accurate information necessary to determine the actual financial impact is not available from the documentation sources identified in § 455.304(c). The estimated financial impact would use the most reliable available information (for example, related source documentation such as data from State systems, hospitals' audited financial statements, and Medicare cost reports) to quantify an audit finding as accurately as possible. We noted our belief that this additional data reporting element is necessary to better enable our oversight of the

Medicaid DSH program to better ensure compliance with the hospital-specific DSH limit in section 1923(g) of the Act.

Additionally, we proposed to add § 447.299(f), which would codify our existing policy for how overpayments identified through the annual independent certified DSH audits required under part 455, subpart D, must be handled and reported to CMS. Specifically, we proposed that DSH payments found in the independent certified audit process under part 455, subpart D, to exceed hospital-specific limits are provider overpayments for which FFP must be returned to the Federal Government in accordance with the requirements in 42 CFR part 433, subpart F, or redistributed by the State to other qualifying hospitals, if redistribution is provided for under the approved State plan. We proposed that overpayment amounts returned to the Federal Government must be separately reported on the Form CMS-64 as a decreasing adjustment which corresponds to the fiscal year DSH allotment and Medicaid SPRY of the original DSH expenditure claimed by the State.

We further proposed to add § 447.299(g), which would establish reporting requirements concerning the redistribution of DSH overpayments in accordance with a State's redistribution methodology in its Medicaid State plan, as applicable. Specifically, we proposed that, as applicable, States would be required to report any overpayment redistribution amounts on the Form CMS-64 within 2 years from the date of discovery that a hospital-specific limit has been exceeded, as determined under § 433.316(f) in accordance with a redistribution methodology in the approved Medicaid State plan. The State would be required to report redistribution of DSH overpayments on the Form CMS-64 as separately identifiable decreasing adjustments reflecting the return of the overpayment as specified in § 447.299(f) and increasing adjustments representing the redistribution by the State. Both adjustments must correspond to the fiscal year DSH allotment and Medicaid SPRY of the related original DSH expenditure claimed by the State. These proposed additions of paragraphs (f) and (g) to § 447.299 would memorialize our current policy concerning the return of FFP in or redistribution of Medicaid DSH payments in

excess of the hospital-specific limit in regulation, and thereby promote clarity and transparency, avoid misunderstanding, and enhance oversight of the Medicaid DSH program.

We explained that these proposals for the independent certified audit and DSH-related claims reporting would enhance Federal oversight of the Medicaid DSH program and improve the accuracy of DSH audit overpayments identified and collected through annual DSH audits. We invited comments on these proposals. The following is a summary of the public comments we received and our responses.

Comment: A few commenters expressed concerns about the language regarding auditors' ability to provide an estimate of the financial impact. One commenter opposed the provision on the basis that overpayment determinations would be based on estimates. Another commenter sought clarity on how an auditor would be able to submit an estimated range of impact.

Response: We want to clarify our language around the use of estimates and financial impact ranges, and our expectation for how States should handle estimated financial impacts. First and foremost, we emphasize that we expect auditors to calculate an actual financial impact of their audit findings wherever possible. Experience has shown that currently, some States' contracts with auditors do not require any quantification of overpayments, leaving this critical activity incomplete following completion of the audit. By finalizing this new data element proposal, we intend to require that State contracts with auditors must require the auditor to take the extra step of quantifying the financial impact of their findings, based on the audit work already being performed. We intend to stop the practice of a State's acceptance of auditor "caveats" unaccompanied by a statement of actual or estimated financial impact, which leaves unnecessary duplicative and burdensome work to the State and CMS to determine any associated overpayment amount. We believe the additional cost and burden associated with the new data element would be minimal given that auditors are already engaged in a focused review of available documentation to quantify the aggregate amounts that comprise each of the existing data elements required under § 447.299(c).

However, as stated in the proposed rule, we acknowledge that even where State contracts with auditors require the auditor to quantify the actual or estimated financial impact of any findings, there are rare circumstances where the financial impact of an identified issue cannot be quantified. As commenters noted, we would allow the auditor to submit an estimated impact in these expectedly rare circumstances. We want to clarify that the reference to an "estimated range of financial impact"[28] in the proposed rule was intended to refer to this circumstance. We also want to clarify that we do not require that States treat an estimate an auditor produces in this context as a determination of an overpayment amount. Consistent with our characterization of overpayments in § 433.316(c)(1) through (3), an estimate would reflect an inability to calculate a specific amount and would not represent a quantified overpayment. It is our expectation that more auditors, by employing appropriate methods at their professional discretion, have the ability to quantify these amounts, than are currently being required to do so under their contracts with the relevant State. If an auditor is truly unable to quantify a finding or caveat using its best professional efforts, the auditor should recommend specific corrective action in its audit report. We expect that the States will submit a corrective action plan as part of the final audit report for CMS approval. Additionally, we remind States that under 42 CFR 431.992, a corrective action plan may be required for possible payment error in association with the Payment Error Rate Measurement process described at 42 CFR 431.950 *et seq*. We realize that given the independent certified DSH audit and report is not due to us until the end of the calendar year 3 years following the end of each SPRY, there may be a significant lag between when an auditor identifies an issue and when the State and hospitals are able to implement corrective action. We intend to take this lag into consideration in determining whether the State's annual audit and DSH payments meet Federal requirements. We may use the deferral and/or disallowance of FFP per § 447.299(e) to ensure timely compliance with Federal DSH reporting requirements.

[28] 88 FR 11865 at 11876.

Comment: One commenter requested that CMS provide standardized guidance for how to calculate and quantify any errors and overpayment amounts. They were concerned that variations in methodology would result in disparate and possibly inequitable impacts from the new data element.

Response: We understand the desire for standardized guidance, and we did consider this option. However, we are finalizing as proposed and will continue to evaluate the need for additional CMS guidance. We expect auditors to utilize their professional discretion to determine how to best quantify errors and overpayment amounts. Allowing this flexibility acknowledges the potential variability in issues an auditor may identify. In addition, auditors are not wholly without guidance on this issue. Auditors should utilize the source documents discussed throughout the 2008 DSH audit final rule to develop their calculations.[29] Finally, as always, we are available to assist any States seeking to develop or enhance their instructions to auditors.

Comment: A few commenters expressed concerns on burden and auditors' ability to quantify data caveats. Specifically, one commenter opposed the proposed new data element because the requirement to quantify data caveats would present a significant burden on States to pay for that level of audit. They recommended that instead CMS should target States with the highest DSH allotments for this new requirement or that CMS should hire a vendor to perform all audits. Another commenter stated that CMS lacked data supporting the assertion that auditors could easily quantify their findings, or that it would be rare for an auditor to need to provide an estimate.

Response: We disagree that this new requirement will constitute a significant burden increase. If an auditor is already completing a full review of DSH documentation, then the information needed to calculate amounts should be readily available and the calculation of

[29] See for example 73 FR 77904 at 77917 for types of source documentation, which can include hospital cost reports, hospital financial statements, and other hospital accounting records.

associated amounts would not create a significantly burdensome additional step. In other words, if an auditor is performing a review of all available documentation in order to produce the audit, then they have the documentation that will inform how payments were made and whether claims for FFP are supported, which should allow the auditor to identify and calculate any possible overpayments. If a State is finding there is a significant change in effort to meet this additional requirement, it could be an indication that previous audit contracts were too limited to result in an independent certified audit sufficient to identify whether DSH payments to hospitals were consistent with each provider's hospital-specific DSH limit. In addition, because we are allowing flexibility in methodology, an auditor could (and should) utilize an approach that minimizes unnecessary burden while still arriving at a mathematically valid final calculation. As discussed in a previous response, experience has shown that some States have limited contracts with their auditors to meet minimum requirements, which results in audit reports that rely heavily on data caveats and are limited in their usefulness for identifying overpayment amounts.

The DSH audits are statutorily required under section 1923(j) of the Act, which places the requirement on the States to perform the audit. All States that make DSH payments must comply with the independent certified audit requirements as a condition of receipt of FFP in their DSH payments. We do not believe the statute contemplates applying more stringent audit standards only to some States. We believe this new requirement is important to ensuring that payments are being made properly, regardless of the potential amount of overpayment that could have occurred in a given State.

Additionally, section 1923(j) of the Act requires States, not CMS, to submit an independent certified audit. We therefore established in the 2008 DSH final rule the requirement for States to contract with an independent auditor to meet this requirement; CMS does not have authority to hire a vendor to perform all independent certified audits, and to do so would duplicate a requirement that Congress has placed on the States. We note that FFP is available in States' allowable administrative expenditures for their audit contracts.

Lastly, regarding the comment stating CMS lacked data supporting the assertion auditors could easily quantify their findings, we have heard from various auditors directly that they can provide more data but are not presently being requested by States to do so. This information about auditors' experiences is why we are confident it would be unlikely that an auditor would need to provide an estimated financial impact amount in more than rare circumstances. Therefore, we are finalizing this required data element with the expectation that States will contract with auditors to take the appropriate steps to quantify findings for which some States' auditors have been including data caveats.

Comment: A few commenters expressed concern in regard to the implementation of the new data element and its interplay with the other data elements. One commenter requested that CMS clarify how the new data element would be used. They specifically inquired if CMS would calculate a new total annual UCC since the commenter perceived that the new data element quantifying any overpayments would not necessarily be reproducible from the other data elements already included in the audit. On the other hand, another commenter questioned whether an amount quantified under this new requirement would not be already accounted for in other data elements of the audit and expressed concern about duplication of effort.

Response: The intent of the new data element, to the extent an auditor has provided actual calculations of impacts, is for States to treat it as an identified overpayment amount. It relates to a quantification of errors, and errors should not be represented in the other data elements of the report, as amounts inclusive of errors would presumably be unsupported by documentation, inaccurate, or otherwise inappropriate. A State's calculated UCC or hospital-specific DSH limit should not include errant or unsupported data, and therefore the quantification included in the new data element should not impact the UCC/hospital-specific DSH limit or necessitate a change.

If the State plan methodology allows for redistribution that would result in changes to DSH audit data elements, we would expect the State to reflect the redistribution-related changes

to applicable data elements in relevant CMS-64s and in revised data element reports. The impacts calculated under the new data element should not duplicate any other data elements in content, but should be consistent with and may be calculated based on other required data elements, as determined by the auditor. Additionally, we are finalizing at § 447.299(c)(21) language that specifically states the amount for the new data element should include amounts "not otherwise reflected in data elements described in this paragraph (c)."

Comment: A few commenters express concern on the parameters of the new data element. Specifically, one commenter questioned if "disclosures" should be regarded as the types of data caveats and errors that an auditor would be required to quantify under this new requirement. Another requested an exception to the requirement when a State is aware an addendum is forthcoming on an audit.

Response: We are unsure precisely what the commenter meant by their use of "disclosure." If "disclosure" is being used synonymously with data caveat and is included in lieu of providing a calculated impact where it would be possible to state the actual or estimated financial impact of an identified issue, then this information would be covered by the new requirement we are finalizing in this rule. If the "disclosure" is merely to make CMS aware of a qualitative circumstance that, by nature, could not be associated with a quantified financial impact, we would not expect an auditor to attempt to produce an actual or estimated impact.

There is no exception to this data requirement, or independent certified audit deadlines in general, when a State or auditor knows a change or addendum to the audit report is forthcoming. Existing regulations at § 433.320(c) contemplate scenarios where an overpayment amount is subsequently adjusted and provides the requirements and procedures for how to address those changes. In addition, frequently asked question (FAQ) #17 of the "Additional Information on the DSH Reporting and Audit Requirements" guidance[30] explains that States have 3 years beyond the applicable FFY for ongoing report and audit submission, in recognition of potential

[30] *https://www.medicaid.gov/medicaid/downloads/part-1-additional-info-on-dsh-reporting-and-auditing.pdf*.

delays in obtaining needed information. Based on the audit and reporting deadlines, the requirement in § 447.45(d) for provider claims to be filed within a year from the date of service and promptly paid by the State, and the 2-year timely claim filing requirement in 45 CFR 95.7, we explained in FAQ #17 that there should not be a significant adjustment to Medicaid payments that would warrant a corrected audit and report. However, we acknowledge there is still a possibility that a significant adjustment to Medicaid payment may occur for which the State claims Federal matching dollars (or returns Federal matching dollars) as a prior period adjustment, falling outside the timely claims filings we would expect to be reflected in original audit submissions. In these instances, the State should submit corrected audits and data element reports in the same manner as the originals, indicating post-audit adjustments to Medicaid and DSH payments that are reflected in the audit or report (or uncompensated care costs if Medicaid payment adjustments affect the Medicaid shortfall) once those adjustments have been made.

Comment: One commenter expressed concern about the disparate impact this requirement may have for hospitals that disproportionately experience certain data issues outside of a State's or hospital's control, such as a hospital with a high volume of out-of-State patients that cause delays in obtaining necessary documentation.

Response: We want to emphasize that, although we hope this new requirement will compel action by States to contract for, ensure the completion of, and submit thorough DSH audits, there is still flexibility for those limited scenarios where an auditor simply cannot obtain the data or employ appropriate mathematical methods to quantify the financial impact of an identified issue. We proposed that auditors would be able to provide an estimated financial impact in these situations. We also note that under existing policy and as finalized in this section of this final rule, States have 3 years beyond the applicable FFY to submit audits, and 2 years following the identification of an overpayment to perform redistributions, as applicable under the State plan. The regulations at § 433.320, as mentioned previously, also contemplate subsequent adjustments to identified overpayment amounts.

Comment: A few commenters requested changes or sought clarity around the scope of the overpayment policy in § 447.299(f). Specifically, one commenter requested an exception to the requirement to recoup or redistribute an identified overpayment as described in § 447.299(f) if the State knows an audit modification is forthcoming in the near future that would require a revised redistribution or recoupment. Another comment requested clarification about how States should handle an underpayment identified in the new DSH data element if the State had not paid out its entire DSH allotment initially and its approved DSH payment methodology called for additional payments to one or more DSH hospitals with room under the hospital-specific DSH limit.

Response: We are finalizing the § 447.299(f) provision as proposed and without an exception to this provision when a State knows a change to the independent certified audit report is likely to be forthcoming. As mentioned in a previous response, we already allow States 3 years beyond the applicable FFY for ongoing report and audit submission under § 455.304(b). In addition, if an overpayment is discovered later, then that overpayment would be subject to the same requirements as any other State Medicaid overpayment, and should be handled in accordance with part 433, subpart F. While we appreciate that there may be rare circumstances when certain information is not available in time to meet these deadlines, we think the time allowed is more than adequate for the vast majority of cases and do not believe that an extension or indefinite timeframe for the independent certified audit and report would be appropriate.

States retain considerable flexibility to design a payment adjustment methodology for DSH hospitals. If States choose to pay up to a hospital's UCC (the full extent of its hospital-specific DSH limit, subject to available funds within the State's Federal Medicaid DSH allotment), in some instances, the DSH audit may identify hospitals that were not paid up to their uncompensated care cost as provided in the State's approved DSH payment methodology. If the State plan outlines an interim payment methodology, the State may be able to make additional DSH payments or redistribute amounts from hospitals that received excess DSH payments (over

their hospital-specific DSH limits) to these hospitals with remaining uncompensated care costs through a reconciliation process to address the "underpayment."

Comment: One commenter sought clarification regarding how the effective date of the rule would impact States with respect to § 447.299(g); for example, the commenter sought clarification on how this new requirement would impact States currently performing redistributions on amounts from more than 2 years prior. The commenter also inquired from what date related to a discovered overpayment a State would have 2 years to redistribute.

Response: We are finalizing § 447.299(g) as proposed. The 2-year policy for redistribution will apply for overpayments identified from the effective date of this final rule, onward. However, this policy has already been communicated directly to States, which have been aware of the two-year timeframe for performing redistributions provided for under the State's approved DSH payment methodology; this final rule merely codifies this existing policy in regulation. If a State is currently processing older redistributions, then the State should make every effort to come into compliance within the timeframes established in this final rule as expeditiously as possible.

Regarding the date of discovery of an overpayment, we intend the 2-year timeframe for redistribution to be determined consistent with the policy we are finalizing at § 433.316(f), where we define the date of discovery of a DSH audit overpayment.

Comment: One commenter was in favor of the redistribution provisions in proposed § 447.299(f) and (g) for the clarity they would provide States on an issue that had multiple reasonable interpretations, but suggested CMS collect hospital-specific data following any redistributions.

Response: We thank the commenter for their suggestion. When our analysts who perform reviews of State-submitted CMS-64s receive a CMS-64 that indicates redistributions, and a State has not otherwise provided updated hospital-specific data in a revised data elements report after the submission of the independent certified audit for the relevant year, we perform

outreach to confirm the new hospital-specific payment amounts and hospital-specific DSH limits and to instruct the State to submit a revised data elements report reflecting these new amounts.

We are finalizing the provisions to § 447.299 as proposed, with minor phrasing changes to § 447.299(c)(6), (c)(10) introductory text, (c)(10)(ii), and (c)(16) replacing "pursuant to" with "in accordance with" to align with current style guidelines.

F. Definitions (§ 455.301)

We proposed to revise the definition of the "independent certified audit" to include the requirement for auditors to quantify the financial impact of each audit finding, or caveat, on an individual basis, for each hospital, per the reporting requirement in proposed § 447.299(c)(21) and under section 1923(j)(1)(B) of the Act. We explained that updating this definition is consistent with the goals of the updates to § 447.299(c)(21) to facilitate our determination of whether the State made DSH payments that exceeded any hospital's specific DSH limit in the Medicaid SPRY under audit. Specifically, as discussed in item five of the proposed provisions, we proposed to add to annual DSH reporting required under § 447.299(c) a requirement for States to report the financial impact of audit findings identified by the State's independent auditor. To align with this proposal, we proposed to revise the definition of the independent certified audit under § 455.301 to include the auditor's certification of "a quantification of the financial impact of each audit finding on a hospital-specific basis." As previously discussed, based on current independent certified DSH audit submissions, we are at times unable to determine whether a DSH overpayment to a provider has occurred, the underlying cause of any overpayment, and the amount of the overpayment(s) associated with each cause. This is the result of an auditor including audit findings or caveats indicating that missing information or other issues may have an impact on the calculation of total uncompensated care costs (that is, the hospital-specific DSH limit), while not making a determination of the actual (or estimated) financial impact of the identified issue. As such, we noted our belief that revising the definition

to include a quantification of the financial impact of any issues identified in the audit is necessary to better ensure proper oversight and integrity of the DSH program.

We solicited comments related to the proposed change. We did not receive public comments on this provision and are finalizing as proposed these changes to § 455.301.

G. Condition for Federal financial participation (FFP) (§ 455.304)

We proposed to revise § 455.304(d)(1), (3), (4), and (6) to reflect the proposed revisions to the independent certified data elements at § 447.299(c)(6), (7), (10), and (16). The revisions would reflect the statutory changes made by section 203 of the CAA 2021, updating the independent certified audit verifications as they relate to the treatment of Medicaid eligibles and third-party payers. We reviewed the other independent certified audit verifications in § 455.304(d) to determine if additional updates were necessary to account for the changes made by section 203 of the CAA 2021. However, we noted our belief that these are the only verifications requiring updates because these are the verifications that consider the treatment of Medicaid eligibles for purposes of the independent certified audit. Therefore, it is only necessary to revise § 455.304(d)(1), (3), (4), and (6) to account for the statutory changes made by section 203 of the CAA 2021.

Accordingly, we proposed to revise § 455.304(d)(1), which specifies that auditors should verify that each qualifying hospital that receives DSH payments, associated with the provisions of services to "Medicaid eligible individuals and individuals with no source of third-party coverage," is allowed to retain that payment. We proposed this change because for most hospitals, for SPRYs beginning on or after October 1, 2021, the methodology by which these DSH payments are calculated and paid will be reflective of Medicaid costs and payments associated with Medicaid eligible individuals for whom Medicaid is the primary payer. Therefore, we proposed to revise § 455.304(d)(1) to remove the reference to Medicaid eligible individuals and update the regulatory text to indicate that the DSH payments are associated with

inpatient hospital and outpatient hospital services provided to Medicaid individuals as determined in accordance with § 447.295(d).

We also proposed to revise § 455.304(d)(3), which specifies that "[o]nly uncompensated care costs of furnishing inpatient and outpatient hospital services to Medicaid eligible individuals" and the uninsured should be included in the calculation of the hospital-specific DSH limit. We proposed this change because for most hospitals, for SPRYs beginning on or after October 1, 2021, only costs incurred on behalf of Medicaid eligible individuals for whom Medicaid is the primary payer will be counted in the calculation of the hospital-specific DSH limit. Therefore, we proposed to revise § 455.304(d)(3) to remove the reference to Medicaid eligible individuals and update the regulatory text to indicate that uncompensated care costs for furnishing inpatient hospital and outpatient hospital services to Medicaid individuals is determined in accordance with § 447.295(d). We also proposed to revise § 455.304(d)(3) to streamline this provision by removing a redundant reference to section 1923(g)(1)(A) of the Act.

Further, we proposed to revise § 455.304(d)(4), which specifies that Medicaid payments, including FFS, supplemental/enhanced, and Medicaid managed care payments made to a hospital "for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individuals," should be included in the calculation of the hospital-specific DSH limit. We proposed this change because for most hospitals, for SPRYs beginning on or after October 1, 2021, only costs incurred on behalf of Medicaid eligible individuals for whom Medicaid is the primary payer will be counted in the calculation of the hospital-specific DSH limit. Therefore, we proposed to revise § 455.304(d)(4) to remove the reference to Medicaid eligible individuals and update the regulatory text to indicate that the DSH payments associated with inpatient hospital and outpatient hospital services provided to Medicaid individuals as determined in accordance with § 447.295(d) are included in the calculation of hospital-specific DSH limit.

Finally, we proposed to revise § 455.304(d)(6), which requires that auditors include a description of the methodology for calculating each hospital's hospital-specific DSH limit,

including "how the State defines incurred inpatient hospital and outpatient hospital costs for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individuals." We proposed this change because for most hospitals, for SPRYs beginning on or after October 1, 2021, the methodology by which these DSH payments were calculated and paid will be reflective of Medicaid costs and payments associated with Medicaid eligible individuals for whom Medicaid is the primary payer. Therefore, we proposed to revise § 455.304(d)(6) to remove the reference to Medicaid eligible individuals and update the regulatory text to indicate that inpatient hospital and outpatient hospital services provided to Medicaid individuals are determined in accordance with § 447.295(d).

We proposed that these and other CAA 2021-related proposals, noted in the respective sections, be applicable to fiscal years beginning on or after October 1, 2021, to align with the effective date of the CAA 2021.

We solicited comments on these proposed changes. We did not receive public comments on the proposed changes to § 455.304 and are finalizing them as proposed, with minor phrasing changes to § 455.304(d)(1), (3), (4), and (6) replacing "pursuant to" with "in accordance with" to align with current style guidelines.

H. Process and calculation of State allotments for FYs after FY 2008 (§ 457.609)

We have not published CHIP allotments in the **Federal Register** since the FY 2013 CHIP allotments. Each year following FY 2013, States have been notified of their CHIP allotments through email notifications or MBES/CBES. We proposed to remove from § 457.609(h), which references our discretionary option to publish in the **Federal Register** the national CHIP allotment amounts as determined on an annual basis for the FYs specified in statute. Instead, we proposed to post CHIP allotments in the MBES/CBES and at Medicaid.gov (or similar successor systems or websites) annually. We noted our belief that posting the CHIP allotment amounts at Medicaid.gov and in the MBES/CBES is an efficient way to increase

transparency by making the information more easily accessible to interested parties and would be less administratively burdensome for us.

We solicited comments related to this proposed change and received public comments. The following is a summary of the public comments we received and our responses.

Comment: Several commenters mentioned the CHIP **Federal Register** publication. Most of these comments were combined with the comments on the DSH allotment publication proposal, discussed earlier in this final rule. The concerns cited in those comments were related to the lack of transparency of MBES/CBES publications because those are not available to the public, and the accountability of a report being posted on Medicaid.gov, because a website can be changed while the **Federal Register** produces static, dated publications. One comment opposed the removal of the April 1 target publication date for CHIP allotments.

Response: We are finalizing this policy as proposed. Although the CHIP allotment publication proposal and the DSH allotment publication proposal may appear similar, the CHIP proposal is distinct in that the prior regulation already afforded CMS discretion whether or not to publish the CHIP allotments in the **Federal Register**, which CMS has not done since FFY 2013. Please refer to the response in section II.A.4. of this rule, "Limitations on Aggregate Payments for DSHs Beginning October 1, 1992," for a response to the DSH allotment publication comments. A couple comments received that referenced CHIP but requested we continue to publish in the **Federal Register** are not actually relevant to CHIP, since CHIP allotments have not been published in the **Federal Register** in recent years.

We also note that the new regulation commits us to publishing final CHIP allotments on Medicaid.gov, which is not currently done, thereby increasing transparency for CHIP allotments. We also note that the current CHIP allotment regulation does not include the April 1 date; that was only part of the similar DSH allotment publication policy we are finalizing in this rule. However, we note the lack of the target date would not affect States receiving their necessary information, a concern cited by the commenter. As with the DSH allotments, we inform States

as soon as information is available about their respective allotment amounts. Removing the target date for a final, public report simply affords CMS room to finalize data in instances where a State is late submitting data to CMS.

III. Retroactive Application of the Rule

The amendments made by section division CC, title II, section 203 of the CAA 2021, require that the changes to the calculations of Medicaid hospital-specific DSH limits take effect on October 1, 2021, and apply to payment adjustments made under section 1923 of the Act during fiscal years beginning on or after that date. Accordingly, the CAA 2021 provisions finalized in this rule at §§ 447.295(b) and (d), 447.299(c)(6), (7), (10), and (16), and 455.304(d)(1), (3), (4), and (6) will apply retroactively as set out in statute.

Comment: One commenter expressed concern on the retroactive application of the rule. The commenter requested that we limit the retroactive application to only those provisions that require such an application by statute.

Response: As proposed, we are limiting the retroactive application to those provisions related to the CAA 2021 changes.

IV. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995 (PRA) (44 U.S.C. 3501 *et seq*.), we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a "collection of information" requirement is submitted to the Office of Management and Budget (OMB) for review and approval. For the purpose of the PRA and this section of the preamble, collection of information is defined under 5 CFR 1320.3(c) of the PRA's implementing regulations.

To fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the PRA requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.

- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Our effort to minimize the information collection burden on the affected public, including the use of automated collection techniques.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

In the February 24, 2023 (88 FR 11865) proposed rule, we solicited public comment on each of the aforementioned issues for the sections of the rule that contained information collection requirements. We did not receive any such comments.

A. Wage Estimates

To derive average costs, we used data from the U.S. Bureau of Labor Statistics' (BLS) May 2022 National Occupational Employment and Wage Estimates for all salary estimates (*https://www.bls.gov/oes/2022/may/oes_nat.htm*). In this regard, Table 1 presents BLS' mean hourly wage, our estimated cost of fringe benefits and other indirect costs (calculated at 100 percent of salary), and our adjusted hourly wage.

TABLE 1: National Occupational Employment and Wage Estimates

Occupation Title	Occupation Code	Mean Hourly Wage ($/hr)	Fringe Benefits and Other Indirect Costs ($/hr)	Adjusted Hourly Wage ($/hr)
Accountants and auditors	13-2011	41.70	41.70	83.40
Financial Specialist all other	13-2099	40.18	40.18	80.36
Managers all other	11-9199	67.88	67.88	135.76

As indicated, we are adjusting our employee hourly wage estimates by a factor of 100 percent. This is necessarily a rough adjustment, both because fringe benefits and overhead costs vary significantly from employer to employer, and because methods of estimating these costs vary widely from study to study. Nonetheless, we believe that doubling the hourly wage to estimate total cost is a reasonably accurate estimation method.

B. Information Collection Requirements (ICR)

The following ICR section sets out requirements and burden that are subject to OMB review and approval under the authority of the PRA.

The provisions that are not discussed in this section (IV) of the preamble are not associated with any information collection requirements. In that regard they are not subject to the requirements of the PRA. For this rule's full burden implications, please see the Regulatory Impact Analysis under section V. of this preamble.

1. ICRs Regarding DSH Reporting Requirements (§ 447.299)

The following changes will be submitted to OMB for approval under control number 0938-0746 (CMS-R-266).

Under § 447.299 as finalized in this rule, States will be required to provide an additional data element as part of their annual DSH audit reports. This additional element will require a State auditor to quantify the financial impact of any audit finding not captured within any other data element under § 447.299(c), which may affect whether each hospital has received DSH payments for which it is eligible within its hospital-specific DSH limit.

The additional data element requires auditors to indicate the financial impact of all findings rather than indicating that the financial impact of any finding is unknown.

The burden consists of the time it would take each State to quantify any audit finding identified during the independent certified audit required under section 1923(j)(2) of the Act. As we rarely receive audits with no identified findings, we assume (for the purposes of this estimate) that all applicable States will complete this work. The territories have been excluded from this requirement since they do not receive a DSH allotment under section 1923(f) of the Act. We have also excluded Massachusetts from the total burden estimate, as it currently does not complete DSH audits because its entire DSH allotment amount is diverted for payments under a section 1115 demonstration project.

We believe the additional burden associated with the new data element would be 2 hours given that auditors are already engaged in a focused review of available documentation to quantify the aggregate amounts that comprise each of the existing data elements required under § 447.299(c). We estimate that the 2 hours would consist of 1 hour at $80.36/hr for a financial specialist to add the additional data to the report and 1 hour at $135.76/hr for management and professional staff to review the additional data in the report. In aggregate we estimate an annual burden of 100 hours (50 States x 2 hr/response x 1 response/year) at a cost of $10,806 (50 States x [(1 hr x $135.76/hr) + (1 hr x $80.36/hr)]).

If the auditor is unable to determine the actual financial impact amount of an audit finding, the auditor would be required to provide a statement of the estimated financial impact for each audit finding identified in the independent certified audit. For the purposes of this burden estimate, we assume that every State may have some quantifiable findings and some unquantifiable findings. As such, we anticipate that a State auditor would have to spend an additional 1 hour at $83.40/hr quantifying the financial impact of DSH findings that are classified as unknown. In aggregate, we estimate an annual burden of 50 hours (50 States x 1 hr) at a cost of $4,170 (50 hr x $83.40/hr).

When taking into account the 50 percent Federal administrative match, we estimate an annual cost of $7,488 ([$10,806 + $4,170] x 0.5).

C. Summary of Annual Burden Estimates

Table 2 summarizes the burden for the provisions.

TABLE 2: Annual Recordkeeping and Reporting Requirements

Regulation Section(s) under title 42 of the CFR	OMB Control Number (CMS ID Number)	Respondents	Responses (per State)	Total Responses	Time per Response (hours)	Total Annual Time (hours)	Labor Costs ($/hr)	Total Cost ($)	State Share ($)
§ 447.299 DSH audit	0938-0746 (CMS-R-266)	50	1	50	2	100	varies	10,806	5,403
		50	1	50	1	50	83.40	4,170	2,085
Total		50	2	100	varies	150	varies	14,976	7,488

In this rule our proposed burden estimates have been adjusted by using BLS' most recent wage estimates (May 2022 vs May 2021) and by accounting for 50 respondents, instead of the 51 respondents that was accounted for in our proposed rule to remove Massachusetts as it currently does not complete DSH audits because its entire DSH allotment amount is diverted for payments under a section 1115 demonstration project.

V. Regulatory Impact Analysis

A. Statement of Need

This final rule will codify in Federal regulations the statutory requirements of division CC, title II, section 203 of the CAA 2021, which relate to Medicaid shortfall and third-party payments. These changes are necessary to align with Federal statute and to provide States and hospitals an understanding of how qualifying hospitals' DSH payments may be impacted by the CAA 2021. These changes are necessary in order to reflect the statutory changes to section 1923(g) of the Act to update the methodology for calculating the Medicaid shortfall portion of the hospital-specific DSH limit to only include costs and payments for hospital services furnished to beneficiaries for whom Medicaid is the primary payer, and to codify the exception for certain hospitals that are in the 97th percentile or above of all hospitals with respect to the number of Medicare SSI days or percentage of Medicare SSI days to total inpatient days. Since we were required to engage in rulemaking to codify the statutory changes made under the CAA 2021, we also took the opportunity to update certain DSH regulations to provide additional clarity and efficiency. The changes to the BNF and associated calculations performed under the DHRM will provide better clarity for States that divert all or a portion of their DSH allotment under an approved section 1115 demonstration. We are also adding additional specificity to the reporting requirements of the annual DSH audit conducted by an independent auditor, which will enhance Federal oversight of the Medicaid DSH program. Additionally, we will improve the accurate identification and collection of overpayments identified through the annual DSH independent certified audits by specifying the date of discovery and standards for return of FFP

or redistribution of DSH payments made to providers in excess of the hospital-specific limit. Finally, this final rule will alleviate the administrative burden of publishing the annual DSH and CHIP allotments in the **Federal Register**, of which we also notify States directly by providing notification through other, more practical means.

B. Overall Impact

We have examined the impacts of this final rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96-354), section 1102(b) of the Act, section 202 of the Unfunded Mandates Reform Act of 1995 (March 22, 1995; Pub. L. 104-4), Executive Order 13132 on Federalism (August 4, 1999), and the Congressional Review Act (5 U.S.C. 804(2))

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). The Executive Order 14094, entitled "Modernizing Regulatory Review" (hereinafter, the Modernizing E.O.), amends section 3(f)(1) of Executive Order 12866 (Regulatory Planning and Review). The amended section 3(f) of Executive Order 12866 defines a "significant regulatory action" as an action that is likely to result in a rule: (1) having an annual effect on the economy of $200 million or more in any 1 year(adjusted every 3 years by the Administrator of OMB's Office of Information and Regulatory Affairs (OIRA) for changes in gross domestic product), or adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, territorial, or tribal governments or communities; (2) creating a serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raise legal or

policy issues for which centralized review would meaningfully further the President's priorities or the principles set forth in this Executive order, as specifically authorized in a timely manner by the Administrator of OIRA in each case.

A regulatory impact analysis (RIA) must be prepared for major rules with significant regulatory action/s and/or with significant effects as per section 3(f)(1) ($200 million or more in any 1 year). Based on our estimates using a "no action" baseline, OIRA has determined that this rulemaking is "significant" under section 3(f)(1) and meets the criteria set forth in 5 U.S.C. 804(2) under subtitle E of the Small Business Regulatory Enforcement Fairness Act of 1996 (also known as the Congressional Review Act)".

C. Detailed Economic Analysis

Some amendments made by the CAA 2021 required us to propose regulatory updates, but there are statutory changes that are effective regardless of our actions. Typically, under OMB Circular A-4, our analysis for instances such as this would utilize a "pre-statute" baseline. However, we are unable to assess the impact of the statutory changes in a meaningful way due to the potential for variation in the Medicare cost reporting and claims data, as well as supplemental security income eligibility data, that inform the new standard. Additionally, the ranking created by those data whereby an unknown 3 percent of entities would have the higher of two options, further inhibited our ability to estimate the impact in a meaningful way. Therefore, for the assessment of incremental economic impact that appears below, we compare the effects of this rulemaking against a "no action" baseline. This baseline incorporates the statutory changes made by the CAA 2021 that do not require rulemaking to be in effect, such as the change to the definition of Medicaid shortfall. This will be the focus of our analysis. Similarly, for the non-CAA 2021-required or related DSH provisions in the proposed rule, our analytical baseline is a direct comparison between the proposed provisions and not finalizing this rule.

Because the impact of our rule depends on downstream impacts of changes created in statute unaffected by this rulemaking, such as the change to only include Medicaid costs and

payments in the hospital-specific DSH limit when Medicaid is the primary payer, calculating financial cost and transfer impacts specific to this rulemaking presents challenges which we will discuss further in those sections.

1. Benefits

The policies in this final rule will enhance Federal oversight of the Medicaid DSH program, improve the accuracy of DSH audit overpayments identified through and collected as a result of annual DSH audits, and provide clarity on certain existing Medicaid DSH policies. This final rule will codify certain existing CMS policies, including that the date of discovery of DSH overpayments is determined according to the earliest of the date on which the State submits its annual DSH independent certified audit to CMS, or any of the dates specified in § 433.316(c). Further, this final rule will provide additional transparency regarding the DSH allotment reductions calculated under the DHRM, specifically regarding the BNF, by updating the applicable regulations to specify that amounts diverted under a section 1115 demonstration approved after July 31, 2009, or approved as of that date but for a purpose other than coverage expansion, are subject to reduction under the HMF and HUF. Further, these regulatory updates will provide transparency regarding how the amounts diverted under a section 1115 demonstration are to be determined and applied in the DHRM. In addition, this final rule includes specific details related to the development and application of the data set used to determine the qualification for the exception for 97th percentile hospitals. This final rule details how hospital-specific DSH limits should be calculated under section 1923(g) of the Act and reported in the independent certified audit, as specified in § 447.299(c). Further, the additional data reporting element in § 447.299(c)(21) will strengthen CMS oversight of the Medicaid DSH program and better ensure compliance with the hospital-specific DSH limit under section 1923(g) of the Act. Finally, this final rule will also allow CMS to provide annual DSH and CHIP allotment information in a timely and accessible manner while reducing unnecessary administrative burden by eliminating the §§ 447.297(c) and 457.609 requirement and option,

respectively, to publish these annual allotments in a **Federal Register** notice.

2. Costs

Under § 447.299, this final rule will require States to determine the hospital-specific DSH limit for hospitals meeting the exception for 97th percentile hospitals. For these hospitals, the hospital-specific DSH limit is calculated using the higher value of either the hospital-specific DSH limit amount determined for the hospital under section 1923(g)(1)(A) of the Act as amended by section 203 of the CAA 2021 or the amount determined for the hospital under section 1923(g)(1)(A) of the Act as in effect on January 1, 2020. This amount will be captured under the reporting element at § 447.299(c)(10). While we proposed that CMS will produce the source of data used to identify hospitals qualifying to meet the exception for 97th percentile hospitals, this will require a State auditor to calculate two separate hospital-specific DSH limits and determine the higher value thereof for hospitals meeting this exception. Given this exception applies to a limited number of hospitals and that the identity of these hospitals and the information required to determine their hospital-specific DSH limit amounts under both calculations would be based on readily available information, we believe the additional burden associated with determining the hospital-specific DSH limit for hospitals qualifying under this exception to be minimal.

To estimate the overall burden of adding this requirement for the calculation of the hospital-specific DSH limit for hospitals meeting the exception for 97th percentile hospitals, we considered the number of annual independent certified audits received by CMS in addition to the limited number of hospitals that will qualify under this exception. In order for States to assess which hospitals meet the exception, we estimate that it would take approximately 2 hours, consisting of: 1 hour at $80.36/hr for a financial specialist to prepare the aforementioned spreadsheet report, and 1 hour at $135.76/hr for management and professional staff to review the report. In the aggregate, we estimate an ongoing annual burden of 100 hours (50 States x 2 hr/response x 1 response/year) at a cost of $10,806 (50 States x [(1 hr $135.76/hr) + (1 hr x

$80.36/hr)] or $216.12 per State [$10,806/50 States]). Additionally, we anticipate that a State auditor would have to spend an additional hour verifying the hospital-specific DSH limits for hospitals meeting the exception for 97th percentile hospitals. The estimated annual burden would be 1 hour per State (50 States x 1 hour) 50 hours x $83.40/hr for auditors to complete the audit at a cost of $4,170 per year (50 States x 1 hour x $83.40 per hour). The total cost of this provision of the proposed rule would be $14,976 ($10,806 + $4,170) and 150 hours, or $299.52 and 3 hours per State.

As described in section IV.C.1. of this final rule, the additional DSH audit data reporting element creates a burden of 150 hours at a cost of $14,976, with an average of 3 hours ($299.52 hr / 50 States) at a cost of $299.52 per State Medicaid agency per year ($14,976 / 50 States).

We do not estimate there will be a cost impact related to the DHRM BNF proposal. This proposal merely provides clarification regarding how amounts are determined, and the impact of the policy itself was accounted for the in the 2019 final rule that finalized the factor amounts. Therefore, the only costs would be associated with review of this rule, which are accounted for in part 4 of this section.

Similarly, there will be no cost impact related to the proposals to publish DSH and CHIP allotments through an alternative means. Under current CMS practice, States are already informed of their allotment amounts prior to the **Federal Register** publication, so the removal of that step will not require a change in entities' practices or systems.

3. Transfers

Although the policies discussed in this final rule would affect the calculation of the hospital-specific DSH limit established at section 1923(g) of the Act and some providers may see a decrease in their historic hospital-specific DSH limits, these effects are a direct result of statutory changes rather than the proposals in this rule. In addition, some providers may see an increase in their historic hospital-specific DSH limits, again as a result of the changes made by statute. Further, lower hospital-specific DSH limits for some hospitals may result in States

choosing to distribute higher DSH payments to hospitals that historically had not been paid at higher levels. We note that this rule would not affect the considerable flexibility afforded States in setting DSH State plan payment methodologies to the extent that these methodologies are consistent with section 1923(c) of the Act and all other applicable statutes and regulations. Therefore, we cannot predict whether and how States would exercise their flexibility in setting DSH payments to account for changes in historic hospital-specific DSH limits and how this would affect individual providers or specific groups of providers. We invited comments from State agencies and hospitals providing information or data for the calculation of these estimates. We did not receive any data that would aid in calculating a more accurate estimate. We made minor adjustments to correct the total number of States whose DSH programs would be impacted by the provisions of this rule and to reflect the latest BLS wage data, but otherwise and generally we are finalizing the estimates as proposed.

4. Regulatory Review Cost Estimation

If regulations impose administrative costs on private entities, such as the time needed to read and interpret this final rule, we estimate the cost associated with regulatory review. Due to the uncertainty involved with accurately quantifying the number of entities that will review the rule, we assume that States, Medicaid DSH hospitals, and independent auditors will likely be reviewers of this final rule. We acknowledge that this assumption may understate or overstate the costs of reviewing this rule. It is possible that not all Medicaid DSH hospitals will choose to review individually, or that State agencies will have multiple people in different roles review. Nevertheless, we thought the entities directly or indirectly impacted by this rule served as the best basis. As such, we will assume half of the approximately 2,700 Medicaid DSH hospitals will review the rule, in addition to at least one person from each of the 50 State agencies impacted by this rule, and at least one person from the independent DSH auditor for each of the 50 States, resulting in 1,450 total entities. We welcomed comments on the approach in estimating the number of entities which will review this final rule.

Although this rule has a number of provisions, they more or less all relate to DSH, and we assume entities with DSH equities will review the entire rule. Using the 2022 wage information from the BLS, *https://www.bls.gov/oes/current/oes119111.htm*, for medical and health service managers (Code 11-9111), we estimate that the cost of reviewing this rule is $123.06 per hour, including overhead and other indirect costs. We estimate that it would take approximately 2 hours for the staff to review this final rule. For each entity that reviews the rule, the estimated cost is $246.12 (2 hours x $123.06). Therefore, we estimate that the total one-time cost of reviewing this regulation is $356,874 ($246.12 x 1,450).

D. Alternatives Considered

In developing this final rule, the following alternatives were considered:

1. Not Finalizing the Rule

Despite the effort involved in developing a proposed rule, we still consider whether the effort of finalizing the proposed rule, in general, is worthwhile and necessary additional effort to meet policy goals. As with the proposed rule, we concluded that, due to the changes to regulatory language necessitated by the legislation, rulemaking was necessary. Accordingly, once the decision to issue a final rule was reached, the additional DSH-related provisions were discrete decisions and not part of the calculus of whether to issue a final rule.

2. The Most Recent Cost Reporting Period Reports

As discussed in section II.A.3. of this final rule, we performed additional work to consider where data anomalies that exist in the status of available cost reports should impact our proposal to use the total inpatient days from the cost report with the most updated cost report status, for the most recent cost reporting period, available on the day that the data are pulled, in determining the hospitals that meet the 97th percentile threshold. However, through our additional review we determined our proposal was most in line with the statutory requirement to use the most recent cost reporting period and that anomalies in the status of the most recent reports did not create issues that would affect our decision.

3. Lookback Period for Cost Reporting

CMS considered various alternatives for making the determination regarding how far back the time period of a hospital's cost report could relate in order to be included in the data set for the calculation of hospitals that meet the 97th percentile threshold exception. We proposed not including any cost report ending earlier than September 30, 3 years prior to the March 31 snapshot date for compiling the data set. For the proposed rule, we considered a shorter cutoff, such as excluding any cost report ending earlier than September 30, 2 years prior to the March 31 snapshot date. However, we were concerned that establishing too short of a cutoff could exclude a material number of hospitals due to either delays in hospitals filing cost reports or delays in the transmitting and processing of cost report files into HCRIS. At that time, we also considered a longer cutoff than 3 years, but we were concerned this could create too much variability in the cost reporting periods and would also capture in the data set hospitals that are currently inactive or terminated. While the proposed rule was out for comment, we continued assessing whether expanding to 4 years would be a net positive for DSH hospitals. However, our additional testing did not demonstrate a benefit in expanding to 4 years and therefore we did not amend the proposal in this final rule. We believe the 3-year cutoff is equitable in ensuring there is general consistency in the cost reporting periods used, conforms with the use of "most recent cost reporting period," and is practical for implementation purposes.

E. Accounting Statement and Table

As required by OMB Circular A-4 (available at *https://www.whitehouse.gov/wp-content/uploads/legacy_drupal_files/omb/circulars/A4/a-4.pdf*), we have prepared an accounting statement in Table 3 showing the classification of the costs associated with the provisions of this final rule.

TABLE 3: Accounting Statement--Classification of Estimated Effects

Category	Estimates	Units		
		Year	Discount Rate	Period Covered
Annualized Monetized ($million/year)	0.01	2021	7%	2022 - 2032
	0.01	2021	3%	2022- 2032
Transfers (From Whom to Whom)	**Federal to States**			
Annualized Monetized ($million/year)	0.04	2021	7%	2022
	0.04	2021	3%	2022
Costs	**Regulatory Review Costs**			

F. Regulatory Flexibility Act (RFA)

The RFA requires agencies to analyze options for regulatory relief of small entities, if a rule has a significant impact on a substantial number of small entities. The great majority of hospitals and most other health care providers and suppliers are small entities, either by being nonprofit organizations or by meeting the Small Business Administration definition of a small business (having revenues of less than $9.0 million to $47 million in any 1 year). Individuals and States are not included in the definition of a small entity. As its measure of significant economic impact on a substantial number of small entities, HHS uses a change in revenue of more than 3 to 5 percent. We do not believe that this threshold will be reached by the provisions in this final rule.

This rule establishes requirements that are solely the responsibility of State Medicaid agencies, which are not small entities. Therefore, the Secretary certifies this final rule would not, if issued, have a significant economic impact on a substantial number of small entities.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a metropolitan statistical area and has fewer than 100 beds. This rule will not have a significant impact on the operations of a substantial number of small rural hospitals.

G. Unfunded Mandates Reform Act (UMRA)

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2024, that threshold is approximately $183 million. This rule does not contain mandates that will impose spending costs on State, local, or tribal governments in the aggregate, or by the private sector, in excess of the threshold.

H. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it issues a proposed rule that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has federalism implications. This rule does not impose substantial direct costs on State or local governments, preempt State law, or otherwise have federalism implications.

I. Conclusion

The policies in this final rule will enable CMS to implement statutory changes, strengthen financial oversight, clarify existing financial management policies, and reduce unnecessary administrative burden.

The analysis in this section V., together with the rest of this preamble, provides a regulatory impact analysis. In accordance with the provisions of Executive Order 12866, this final rule was reviewed by the Office of Management and Budget.

Chiquita Brooks-LaSure, Administrator of the Centers for Medicare & Medicaid Services, approved this document on February 15, 2024.

List of Subjects

42 CFR Part 433

Administrative practice and procedure, Child support, Claims, Grant programs—health, Medicaid, Reporting and recordkeeping requirements.

42 CFR Part 447

Accounting, Administrative practice and procedure, Drugs, Grant programs-health, Health facilities, Health professions, Medicaid, Reporting and recordkeeping requirements, Rural areas.

42 CFR Part 455

Fraud, Grant programs-health, Health facilities, Health professions, Investigations, Medicaid, Reporting and recordkeeping requirements.

42 CFR Part 457

Administrative practice and procedure, Grant programs-health, Health insurance, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services amends 42 CFR chapter IV as set forth below:

PART 433—STATE FISCAL ADMINISTRATION

1. The authority citation for part 433 continues to read as follows:

Authority: 42 U.S.C. 1302.

2. Amend § 433.316 by—

a. Redesignating paragraphs (f) through (h) as paragraphs (g) through (i), respectively; and

b. Adding a new paragraph (f).

The addition reads as follows:

§ 433.316 When discovery of overpayment occurs and its significance.

* * * * *

(f) *Overpayments identified through the disproportionate share hospital (DSH) independent certified audit*. In the case of an overpayment identified through the independent certified audit required under part 455, subpart D, of this chapter, CMS will consider the overpayment as discovered on the earliest of the following:

(1) The date that the State submits the independent certified audit report required under § 455.304(b) of this chapter to CMS.

(2) Any of the dates specified in paragraph (c)(1), (2), or (3) of this section.

* * * * *

PART 447 - PAYMENTS FOR SERVICES

3. The authority citation for part 447 continues to read as follows:

Authority: 42 U.S.C. 1302 and 1396r-8.

4. Amend § 447.294 by revising paragraphs (e)(12) introductory text and (e)(12)(i) and (ii) to read as follows:

§ 447.294 Medicaid disproportionate share hospital (DSH) allotment reductions.

* * * * *

(e) * * *

(12) *Section 1115 budget neutrality factor (BNF) calculation.* This factor is only calculated for States for which all or a portion of the DSH allotment was included in the calculation of budget neutrality under a section 1115 demonstration in accordance with an approval on or before July 31, 2009. CMS will calculate the BNF for qualifying States by the following:

(i) For States in which the State's DSH allotment was included in the budget neutrality calculation for a coverage expansion that was approved under section 1115 as of July 31, 2009, determining the amount of the State's DSH allotment included in the budget neutrality calculation for coverage expansion. This amount is not subject to reductions under the HMF and HUF calculations. DSH allotment amounts included in the budget neutrality calculation for purposes other than coverage expansion for a demonstration project under section 1115 that was approved as of July 31, 2009, are subject to reduction as specified in paragraphs (e)(12)(ii) through (iv) of this section. For States whose DSH allotment was included in the budget neutrality calculation for a demonstration project that was approved under section 1115 after July 31, 2009, whether for coverage expansion or otherwise, the entire DSH allotment amount that was included in the budget neutrality calculation is subject to reduction as specified in paragraphs (e)(12)(ii) through (iv) of this section.

(ii) Determining the amount of the State's DSH allotment included in the budget neutrality calculation subject to reduction. The amount to be assigned reductions under paragraphs (e)(12)(iii) and (iv) of this section is the total of each State's DSH allotment diverted under an approved 1115 demonstration during the period that aligns with the associated State plan rate year DSH audit utilized in the DSH allotment reductions.

* * * * *

5. Amend § 447.295 by adding a definition for "97th percentile hospital" in alphanumerical order in paragraph (b) and revising paragraph (d) to read as follows:

§ 447.295 Hospital-specific disproportionate share hospital payment limit: Determination of individuals without health insurance or other third-party coverage.

* * * * *

(b) * * *

97th percentile hospital means a hospital that is in at least the 97th percentile of all hospitals nationwide with respect to the hospital's number of inpatient days or the hospital's percentage of total inpatient days, for the hospital's most recent cost reporting period, made up of patients who were entitled to benefits under part A of title XVIII and supplemental security income benefits under title XVI (excluding any State supplementary benefits paid).

(i) CMS will identify the 97th percentile hospitals, for each Medicaid State plan rate year beginning on or after October 1, 2021, using Medicare cost reporting and claims data sources, as well as supplemental security income eligibility data provided by the Social Security Administration.

(ii) CMS will publish lists identifying each 97th percentile hospital annually in advance of October 1 of each year. CMS will revise a published list only to correct a mathematical or other similar technical error that is identified to CMS during the one-year period beginning on the date the list is published.

* * * * *

(d) *Hospital-specific DSH limit calculation.* (1) For each State's Medicaid State plan rate years beginning prior to October 1, 2021 and subject to paragraph (d)(3) of this section, only costs incurred in providing inpatient hospital and outpatient hospital services to Medicaid individuals, and revenues received with respect to those services, and costs incurred in providing inpatient hospital and outpatient hospital services, and revenues received with respect to those services, for which a determination has been made in accordance with paragraph (c) of this

section that the services were furnished to individuals who have no source of third-party coverage for the specific inpatient hospital or outpatient hospital service are included when calculating the costs and revenues for Medicaid individuals and individuals who have no health insurance or other source of third-party coverage for purposes of section 1923(g)(1) of the Act.

(2) For each State's first Medicaid State plan rate year beginning on or after October 1, 2021, and thereafter, subject to paragraph (d)(3) of this section, only costs incurred in providing inpatient hospital and outpatient hospital services to Medicaid individuals when Medicaid is the primary payer for such services, and revenues received with respect to those services, and costs incurred in providing inpatient hospital and outpatient hospital services, and revenues received with respect to those services, for which a determination has been made in accordance with paragraph (c) of this section that the services were furnished to individuals who have no source of third-party coverage for the specific inpatient hospital or outpatient hospital service are included when calculating the costs and revenues for Medicaid individuals and individuals who have no health insurance or other source of third-party coverage for purposes of section 1923(g)(1) of the Act.

(3) Effective for each State's first Medicaid State plan rate year beginning on or after October 1, 2021, and thereafter, the hospital-specific DSH limit for a 97th percentile hospital defined in paragraph (b) of this section is the higher of the values from the calculations described in paragraphs (d)(1) and (2) of this section.

§ 447.297 [Amended]

6. Amend § 447.297 by:

a. In paragraph (b), removing the phrase “published by April 1 of each Federal fiscal year,” and adding in its place the phrase “posted as soon as practicable,”;

b. In paragraph (c)—

i. Removing the phrase “publish in the FEDERAL REGISTER” and adding in its place the phrase “post in the Medicaid Budget and Expenditure System/State Children's Health Insurance

Program Budget and Expenditure System and at Medicaid.gov (or similar successor system or website)"; and

ii. Removing the phrase "publish final State DSH allotments by April 1 of each Federal fiscal year," and adding in its place the phrase "post final State DSH allotments as soon as practicable for each Federal fiscal year,"; and

c. In paragraph (d)(1)—

i. Removing the phrase "by April 1 of each Federal fiscal year" and adding in its place the phrase "as soon as practicable for each Federal fiscal year"; and

ii. Removing the phrase "prior to the April 1 publication date" and adding in its place the phrase "prior to the posting date"; and

d. Removing paragraph (e).

7. Amend § 447.299 by—

a. Revising paragraphs (c)(6) and (7), (c)(10) introductory text, (c)(10)(ii), and (c)(16);

b. Redesignating paragraph (c)(21) as paragraph (c)(22); and

c. Adding new paragraph (c)(21) and paragraphs (f) and (g).

The revisions and additions read as follows:

§ 447.299 Reporting requirements.

* * * * *

(c) * * *

(6) *IP/OP Medicaid fee-for-service (FFS) basic rate payments.* The total annual amount paid to the hospital under the State plan, including Medicaid FFS rate adjustments, but not including DSH payments or supplemental/enhanced Medicaid payments, for inpatient and outpatient hospital services furnished to Medicaid individuals, as determined in accordance with § 447.295(d).

(7) *IP/OP Medicaid managed care organization payments*. The total annual amount paid to the hospital by Medicaid managed care organizations for inpatient hospital and outpatient

hospital services furnished to Medicaid individuals, as determined in accordance with § 447.295(d).

* * * * *

(10) *Total cost of care for Medicaid IP/OP services.* The total annual costs incurred by each hospital for furnishing inpatient hospital and outpatient hospital services to Medicaid individuals as determined in accordance with § 447.295(d). The total annual costs are determined on a hospital-specific basis, not a service-specific basis. For purposes of this section, costs -

* * * * *

(ii) Must capture the total burden on the hospital of treating Medicaid patients as determined in accordance with § 447.295(d), not including payment by Medicaid. Thus, costs must be determined in the aggregate and not by estimating the cost of individual patients. For example, if a hospital treats two Medicaid patients at a cost of $2,000 and receives a $500 payment from a third party for each individual, the total cost to the hospital for purposes of this section is $1,000, regardless of whether the third-party payment received for one patient exceeds the cost of providing the service to that individual.

* * * * *

(16) *Total annual uncompensated care costs*. The total annual uncompensated care cost equals the total cost of care for furnishing inpatient hospital and outpatient hospital services to Medicaid individuals as determined in accordance with § 447.295(d), and to individuals with no source of third-party coverage for the hospital services they receive, less the sum of regular Medicaid FFS rate payments, Medicaid managed care organization payments, supplemental/enhanced Medicaid payments, uninsured revenues, and section 1011 payments for inpatient and outpatient hospital services. This should equal the sum of paragraphs (c)(9), (12), and (13) of this section subtracted from the sum of paragraphs (c)(10) and (14) of this section.

* * * * *

(21) *Financial impact of audit findings*. The total annual amount associated with each audit finding. If it is not practicable to determine the actual financial impact amount, state the estimated financial impact for each audit finding identified in the independent certified audit that is not otherwise reflected in data elements described in this paragraph (c). For purposes of this paragraph (c), audit finding means an issue identified in the independent certified audit required under § 455.304 of this chapter concerning the methodology for computing the hospital-specific DSH limit or the DSH payments made to the hospital, including, but not limited to, compliance with the hospital-specific DSH limit as defined in paragraph (c)(16) of this section. Audit findings may be related to missing or improper data, lack of documentation, non-compliance with Federal statutes or regulations, or other deficiencies identified in the independent certified audit. Actual financial impact means the total amount associated with audit findings calculated using the documentation sources identified in § 455.304(c) of this chapter. Estimated financial impact means the total amount associated with audit findings calculated on the basis of the most reliable available information to quantify the amount of an audit finding in circumstances where complete and accurate information necessary to determine the actual financial impact is not available from the documentation sources identified in § 455.304(c) of this chapter.

* * * * *

(f) DSH payments found in the independent certified audit process under part 455, subpart D, of this chapter to exceed hospital-specific cost limits are provider overpayments which must be returned to the Federal Government in accordance with the requirements in part 433, subpart F, or redistributed by the State to other qualifying hospitals, if redistribution is provided for under the approved State plan. Overpayment amounts returned to the Federal Government must be separately reported on the Form CMS-64 as a decreasing adjustment which corresponds to the fiscal year DSH allotment and Medicaid State plan rate year of the original DSH expenditure claimed by the State.

(g) As applicable, States must report any overpayment redistribution amounts on the Form CMS-64 within 2 years from the date of discovery that a hospital-specific limit has been exceeded, as determined under § 433.316(f) of this chapter in accordance with a redistribution methodology in the approved Medicaid State plan. The State must report redistribution of DSH overpayments on the Form CMS-64 as separately identifiable decreasing adjustments reflecting the return of the overpayment as specified in paragraph (f) of this section and increasing adjustments representing the redistribution by the State. Both adjustments must correspond to the fiscal year DSH allotment and Medicaid State plan rate year of the related original DSH expenditure claimed by the State.

PART 455 – PROGRAM INTEGRITY: MEDICAID

8. The authority citation for part 455 continues to read as follows:

Authority: 42 U.S.C. 1302.

9. Amend § 455.301 by revising the definition of "Independent certified audit" to read as follows:

§ 455.301 Definitions.

* * * * *

Independent certified audit means an audit that is conducted by an auditor that operates independently from the Medicaid agency or subject hospitals and is eligible to perform the DSH audit. Certification means that the independent auditor engaged by the State reviews the criteria of the Federal audit regulation and completes the verification, calculations and report under the professional rules and generally accepted standards of audit practice. This certification includes a review of the State's audit protocol to ensure that the Federal regulation is satisfied, an opinion for each verification detailed in the regulation, a determination of whether or not the State made DSH payments that exceeded any hospital's hospital-specific DSH limit in the Medicaid State plan rate year under audit, and a quantification of the financial impact of each audit finding on a

hospital-specific basis. The certification also identifies any data issues or other caveats or deficiencies that the auditor identified as impacting the results of the audit.

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10. Amend § 455.304 by revising paragraphs (d)(1), (3), (4), and (6) to read as follows:

§ 455.304 Condition for Federal financial participation (FFP).

* * * * *

(d) * * *

(1) *Verification 1*. Each hospital that qualifies for a DSH payment in the State is allowed to retain that payment so that the payment is available to offset its uncompensated care costs for furnishing inpatient hospital and outpatient hospital services during the Medicaid State plan rate year to Medicaid individuals as determined in accordance with § 447.295(d) of this chapter, and individuals with no source of third-party coverage for the services, in order to reflect the total amount of claimed DSH expenditures.

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(3) *Verification 3*. Only uncompensated care costs of furnishing inpatient and outpatient hospital services to Medicaid individuals as determined in accordance with § 447.295(d) of this chapter, and individuals with no third-party coverage for the inpatient and outpatient hospital services they received are eligible for inclusion in the calculation of the hospital-specific disproportionate share limit payment limit, as described in section 1923(g)(1)(A) of the Act.

(4) *Verification 4*. For purposes of this hospital-specific limit calculation, any Medicaid payments (including regular Medicaid fee-for-service rate payments, supplemental/enhanced Medicaid payments, and Medicaid managed care organization payments) made to a disproportionate share hospital for furnishing inpatient hospital and outpatient hospital services to Medicaid individuals as determined in accordance with § 447.295(d) of this chapter, which are in excess of the Medicaid incurred costs of such services, are applied against the uncompensated

care costs of furnishing inpatient hospital and outpatient hospital services to individuals with no source of third-party coverage for such services.

* * * * *

(6) *Verification 6*. The information specified in paragraph (d)(5) of this section includes a description of the methodology for calculating each hospital's payment limit under section 1923(g)(1) of the Act. Included in the description of the methodology, the audit report must specify how the State defines incurred inpatient hospital and outpatient hospital costs for furnishing inpatient hospital and outpatient hospital services to Medicaid individuals as determined in accordance with § 447.295(d) of this chapter, and individuals with no source of third-party coverage for the inpatient hospital and outpatient hospital services they received.

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PART 457 – ALLOTMENTS AND GRANTS TO STATES

11. The authority for part 457 continues to read as follows:

Authority: 42 U.S.C. 1302.

12. Amend § 457.609 by revising paragraph (h) to read as follows:

§ 457.609 Process and calculation of State allotments for a fiscal year after FY 2008.

* * * * *

(h) *CHIP fiscal year allotment process.* The national CHIP allotment and State CHIP allotments will be posted in the Medicaid Budget and Expenditure System/State Children's Health Insurance Program Budget and Expenditure System and at Medicaid.gov (or similar successor system or website) as soon as practicable after the allotments have been determined for each Federal fiscal year.

Xavier Becerra,

Secretary,

Department of Health and Human Services.

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