Please see the direct final rule which is located in the Rules section of this **Federal Register** for detailed instructions on how to submit comments.

FOR FURTHER INFORMATION CONTACT: Anthony Maietta, Environmental Protection Specialist, Control Strategies Section, Air Programs Branch (AR–18J), Environmental Protection Agency, Region 5, 77 West Jackson Boulevard, Chicago, Illinois 60604, (312)353–8777, *maietta.anthony@epa.gov.*

SUPPLEMENTARY INFORMATION: In the Final Rules section of this **Federal Register**, EPA is approving the State's SIP submittal as a direct final rule without prior proposal because EPA views this as a noncontroversial submittal and anticipates no adverse comments. A detailed rationale for the approval is set forth in the direct final rule. If no adverse comments are received in response to this rule, no further activity is contemplated. If EPA receives adverse comments, the direct final rule will be withdrawn and all relevant public comments received will be addressed in a subsequent final rule based on this proposed rule. EPA will not institute a second comment period. Any parties interested in commenting on this action should do so at this time. Please note that if EPA receives adverse comment on an amendment, paragraph, or section of this rule and if that provision may be severed from the remainder of the rule, EPA may adopt as final those provisions of the rule that are not the subject of an adverse comment. For additional information, see the direct final rule which is located in the Rules section of this **Federal Register**.

Dated: April 30, 2013.

Susan Hedman,

Regional Administrator, Region 5.

[FR Doc. 2013–11454 Filed 5–14–13; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 52

[EPA–R05–OAR–2012–0968 FRL–9812–1]

Approval and Promulgation of Air Quality Implementation Plans; Ohio; Canton-Massillon 1997 8-Hour Ozone Maintenance Plan Revision to Approved Motor Vehicle Emissions Budgets

AGENCY: Environmental Protection Agency (EPA).

ACTION: Proposed rule.

SUMMARY: EPA is proposing to approve the request by Ohio to revise the Canton-Massillon, Ohio, 1997 8-hour ozone maintenance air quality State Implementation Plan (SIP) under the Clean Air Act to replace the previously approved motor vehicle emissions budgets with budgets developed using EPA's Motor Vehicle Emissions Simulator (MOVES) emissions model. Ohio submitted the SIP revision request to EPA on November 26, 2012.

DATES: Comments must be received on or before June 14, 2013.

ADDRESSES: Submit your comments, identified by Docket ID No. EPA–R05–OAR–2012–0968, by one of the following methods:

1. *www.regulations.gov:* Follow the on-line instructions for submitting comments.
2. *Email: blakley.pamela@epa.gov.*
3. *Fax:* (312) 692–2450.
4. *Mail:* Pamela Blakley, Chief, Control Strategies Section, Air Programs Branch (AR–18J), U.S. Environmental Protection Agency, 77 West Jackson Boulevard, Chicago, Illinois 60604.
5. *Hand Delivery:* Pamela Blakley, Chief, Control Strategies Section, Air Programs Branch (AR–18J), U.S. Environmental Protection Agency, 77 West Jackson Boulevard, Chicago, Illinois 60604. Such deliveries are only accepted during the Regional Office normal hours of operation, and special arrangements should be made for deliveries of boxed information. The Regional Office official hours of business are Monday through Friday, 8:30 a.m. to 4:30 p.m., excluding Federal holidays.

Please see the direct final rule which is located in the Rules section of this **Federal Register** for detailed instructions on how to submit comments.

FOR FURTHER INFORMATION CONTACT: Anthony Maietta, Environmental Protection Specialist, Control Strategies Section, Air Programs Branch (AR–18J), Environmental Protection Agency, Region 5, 77 West Jackson Boulevard, Chicago, Illinois 60604, (312) 353–8777, *maietta.anthony@epa.gov.*

SUPPLEMENTARY INFORMATION: In the Final Rules section of this **Federal Register**, EPA is approving the state's SIP submittal as a direct final rule without prior proposal because EPA views this as a noncontroversial submittal and anticipates no adverse comments. A detailed rationale for the approval is set forth in the direct final rule. If no adverse comments are received in response to this rule, no further activity is contemplated. If EPA receives adverse comments, the direct final rule will be withdrawn and all public comments received will be addressed in a subsequent final rule based on this proposed rule. EPA will not institute a second comment period. Any parties interested in commenting on this action should do so at this time. Please note that if EPA receives adverse comment on an amendment, paragraph, or section of this rule and if that provision may be severed from the remainder of the rule, EPA may adopt as final those provisions of the rule that are not the subject of an adverse comment. For additional information, see the direct final rule which is located in the Rules section of this **Federal Register**.

Dated: April 30, 2013.

Susan Hedman,

Regional Administrator, Region 5.

[FR Doc. 2013–11448 Filed 5–14–13; 8:45 am]

BILLING CODE 6560–50–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 447

[CMS–2367–P]

RIN 0938–AR31

Medicaid Program; State Disproportionate Share Hospital Allotment Reductions

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

ACTION: Proposed rule.

SUMMARY: The statute, as amended by the Affordable Care Act, requires aggregate reductions to state Medicaid Disproportionate Share Hospital (DSH) allotments annually from fiscal year (FY) 2014 through FY 2020. This proposed rule delineates a methodology to implement the annual reductions for FY 2014 and FY 2015. The rule also proposes to add additional DSH reporting requirements for use in implementing the DSH health reform methodology.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on July 12, 2013.

ADDRESSES: In commenting, please refer to file code CMS–2367–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (please choose only one of the ways listed):

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

2. *By regular mail.* You may mail written comments to the following address only: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–2367–P, P.O. Box 8016, Baltimore, MD 21244–8016.

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

3. *By express or overnight mail.* You may send written comments to the following address only: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–2367–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

4. *By hand or courier.* Alternatively, you may deliver (by hand or courier) your written comments only to the following addresses prior to the close of the comment period:

a. For delivery in Washington, DC—Centers for Medicare & Medicaid Services, Department of Health and Human Services, Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue SW., Washington, DC 20201.

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without Federal government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

b. For delivery in Baltimore, MD—Centers for Medicare & Medicaid Services, Department of Health and Human Services, 7500 Security Boulevard, Baltimore, MD 21244–1850.

If you intend to deliver your comments to the Baltimore address, call telephone number (410) 786–7195 in advance to schedule your arrival with one of our staff members.

Comments erroneously mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

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

FOR FURTHER INFORMATION CONTACT: Rory Howe, (410) 786–4878 and Richard Strauss, (410) 786–2019.

SUPPLEMENTARY INFORMATION:

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

Comments received timely will also be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1–800–743–3951.

I. Executive Summary

A. Purpose

The statute as amended by the Affordable Care Act sets forth aggregate reductions to state Medicaid disproportionate share hospital (DSH) allotments annually from fiscal year (FY) 2014 through FY 2020. This proposed rule delineates the DSH Health Reform Methodology (DHRM) to implement the annual reductions for FY 2014 and FY 2015.

B. Summary of the Major Provisions

The statute as amended by the Affordable Care Act directs the Secretary to implement the annual DSH allotment reductions using a DHRM. This rule proposes to amend part 447 by establishing the DHRM. The DHRM incorporates five factors identified in the statute.

C. Costs and Benefits

Taking these five factors into account for each state, the proposed DHRM would generate a state-specific DSH allotment reduction amount for FY 2014 and FY 2015. The total of all DSH allotment reduction amounts would equal the aggregate annual reduction amounts identified in the statute for FY 2014 and FY 2015. To determine the effective annual DSH allotment for each state, the state-specific annual DSH allotment reduction amount would be applied to the unreduced DSH allotment amount for its respective state.

II. Background

A. Introduction

As a result of the Affordable Care Act, millions of Americans will have access to health insurance coverage through qualified health plans offered through Health Insurance Exchanges (also called marketplaces) or through the Medicaid program. This increase in the number of individuals having access to health insurance is expected to significantly reduce levels of uncompensated care provided by hospitals.

On the assumption that the number of uninsured people will fall sharply beginning in 2014, the statute reforms an existing initiative under the Medicaid program to address the situation of hospitals which serve a disproportionate share of low income patients and therefore may have uncompensated care costs. Under sections 1902(a)(13)(A)(iv) and 1923 of the Social Security Act (the Act), states are required to make payments to qualifying ''disproportionate share'' hospitals (DSH payments). Section 2551 of the Affordable Care Act amended section 1923(f) of the Act, by adding paragraph (7), to provide for aggregate reductions in federal funding under the Medicaid program for such DSH payments for the 50 states and the District of Columbia. This reform of the DSH payment authority is consistent with the reduction of uncompensated care costs (particularly those associated with the uninsured) expected to result from the expansion of coverage under the statute.

Section 1923(f)(7)(A)(i) of the Act requires that the Secretary of Health and Human Services (the Secretary) implement the aggregate reductions in federal funding for DSH payments through reductions in annual state allotments of federal funding for DSH payments (state DSH allotments), and accompanying reductions in payments to each state. Since 1998, the amount of federal funding for DSH payments for each state has been limited to an annual state DSH allotment in accordance with section 1923(f) of the Act. Section 1923(f)(7) of the Act requires the use of a DHRM to determine the percentage reduction in each annual state DSH allotment to achieve the required aggregate annual reduction in federal DSH funding.

Section 1923(f)(7)(B) establishes the following five factors that must be considered in the development of the DHRM. The methodology must:

- Impose a smaller percentage reduction on low DSH States;
- Impose larger percentage reductions on states that have the lowest

percentages of uninsured individuals during the most recent year for which such data are available;

- Impose larger percentage reductions on states that do not target their DSH payments on hospitals with high volumes of Medicaid inpatients;
- Impose larger percentage reductions on states that do not target their DSH payments on hospitals with high levels of uncompensated care; and
- Take into account 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 as of July 31, 2009.

The statutory provision for each factor contains explicit principles, described below, to apply when calculating the annual DSH allotment reduction amounts for each state through the DHRM.

B. Legislative History and Overview

The Omnibus Budget Reconciliation Act of 1981 (OBRA '81) (Pub. L. 97–35, enacted on August 31, 1981) amended section 1902(a)(13) of the Act to require that Medicaid payment rates for hospitals ''take into account the situation of hospitals that serve a disproportionate share of low-income patients with special needs.'' Over the more than 30 years since this requirement was first enacted, the Congress has set forth in section 1923 of the Act payment targets and limits to implement the requirement and to ensure greater oversight, transparency, and targeting of funding to hospitals.

To qualify as a DSH under section 1923(b) of the Act, a hospital must meet two minimum qualifying criteria in section 1923(d) of the Act. The first criterion is that the hospital has at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to Medicaid individuals. This criterion does not apply to hospitals in which the inpatients are predominantly individuals under 18 years of age or hospitals that do not offer nonemergency obstetric services to the general public as of the date of the enactment of the Act. The second criterion is that the hospital has a Medicaid inpatient utilization rate of at least 1 percent.

Under section 1923(b) of the Act, a hospital meeting the minimum qualifying criteria in section 1923(d) of the Act is deemed as a DSH if the hospital's Medicaid inpatient utilization rate (MIUR) is at least one standard deviation above the mean MIUR in the state, or if the hospital's low-income utilization rate exceeds 25 percent. States have the option to define disproportionate share hospitals under the state plan using alternative qualifying criteria as long as the qualifying methodology comports with the deeming requirements of section 1923(b) of the Act. Subject to certain federal payment limits, states are afforded flexibility in setting DSH state plan payment methodologies to the extent that these methodologies are consistent with section 1923(c) of the Act. Section 1923(f) of the Act limits federal financial participation (FFP) for total statewide DSH payments made to eligible hospitals in each federal FY to the amount specified in an annual DSH allotment for each state. Although there have been some special rules for calculating DSH allotments for particular years or sets of years, section 1923(f)(3) establishes a general rule that state DSH allotments are calculated on an annual basis in an amount equal to the DSH allotment for the preceding FY increased by the percentage change in the consumer price index for all urban consumers for the previous FY. The annual allotment, after the consumer price index increase, is limited to the greater of the DSH allotment for the previous year or twelve percent of the total amount of Medicaid expenditures under the state plan during the FY. Allotment amounts were originally established in the Medicaid Voluntary Contribution and Provider Specific Tax Amendments of 1991 based on each state's historical DSH spending.

Section 1923(g) of the Act also limits FFP for DSH payments by imposing a hospital-specific limit on DSH payments. FFP is not available for DSH payments that exceed the hospital's uncompensated cost of providing inpatient hospital and outpatient hospital services to Medicaid patients and the uninsured, minus payments received by the hospital by or on the behalf of those patients.

The statute, as amended by the Affordable Care Act, requires annual aggregate reductions in federal DSH funding from FY 2014 through FY 2020. The aggregate annual reduction amounts are:

- $500,000,000 for FY 2014;
- $600,000,000 for FY 2015;
- $600,000,000 for FY 2016;
- $1,800,000,000 for FY 2017;
- $5,000,000,000 for FY 2018;
- $5,600,000,000 for FY 2019; and
- $4,000,000,000 for FY 2020.

To implement these annual reductions, the statute requires that the Secretary reduce annual state DSH allotments, and payments to states, based on a DHRM specified in section 1923(f)(7)(B) of the Act. The proposed DHRM relies on the five statutorily identified factors collectively to determine a state-specific DSH allotment reduction amount to be applied to the allotment that is calculated under section 1923(f) of the Act prior to the reductions under section 1923(f)(7) of the Act.

C. The Impact of a State's Decision To Adopt the New Low-Income Adult Coverage Group

The statute provides significant federal financial support for states to extend coverage to low-income adults under section 1902(a)(10)(A)(i)(VIII) of the Act. For a state that implements the new adult coverage group, the state and its hospitals will receive full Medicaid reimbursement for many previously uninsured patients. So on balance, we believe both hospitals and States stand to benefit greatly from expanding Medicaid.

Implementation of the new coverage group is expected to affect the amount of uncompensated care and the percentage of uninsured individuals within states. Generally, we expect that states that do not implement the new coverage group would have relatively higher rates of uninsured, and more uncompensated care, than states that adopt the new coverage group.

Because states that implement the new coverage group would have lower rates of uninsurance, the reduction in DSH funding may be greater for such states compared to States that do not implement the new coverage group. Consequently, hospitals in states implementing the new coverage group that serve Medicaid patients may experience a deeper reduction in DSH payments than they would if all states were to implement the new coverage group. Given the statutory reductions in the funding for Medicaid DSH in the Affordable Care Act, we intend to account for the different circumstances among states in the formula in future rulemaking.

Currently, we do not have sufficient information on the relative impacts that would result from state decisions to implement the new coverage group, and thus we have determined to propose a DHRM only for the first two years during which the DSH funding reductions are in effect. The data that the reductions are based on for these two years will not reflect differential decisions to implement the new coverage group. Data reflecting the effects of the decision to implement the new coverage group may not be available to consider the impact of such a decision until 2016. Therefore, we intend to continue evaluating potential

implications for accounting for coverage expansion in the DHRM. While we are interested in public comment on this issue, we intend to address this issue more completely in separate rulemaking for DSH allotment reductions for FY 2016 and thereafter.

Accordingly, we are proposing to establish a DHRM that would be in effect for FY 2014 and FY 2015 and we are not including a method to account for differential coverage expansions in Medicaid for FY 2014 and FY 2015.

D. DHRM Data Sources

The statute establishes parameters regarding data and/or suggested data sources for specific factors in the development of the DHRM. We are proposing to utilize for the DHRM, wherever possible, data sources and metrics that are transparent and readily available to CMS, states, and the public, such as: United States Census Bureau data, Medicaid DSH data reported as required by section 1923(j) of the Act, existing state DSH allotments, and Form CMS–64 Medicaid Budget and Expenditure System (MBES) data. We are proposing to utilize the most recent year available for all data sources. For one data source, we intend to collect information directly from state Medicaid agencies outside of this rule.

Specifically, we intend for states to submit the information used to determine which hospitals are deemed disproportionate share under section 1923(b) of the Act. Although we do not currently collect this information because states are required to make DSH payments to hospitals that are DSH eligible, states should have this information readily available. To ensure that all hospitals are properly deemed disproportionate share, states must determine the mean MIUR for hospitals receiving Medicaid payments in the state and the value of one standard deviation above the mean. We are also proposing to rely on data derived from Medicaid DSH audit and reporting data. The data is reported by states as required by section 1923(j) of the Act and the ''Medicaid Disproportionate Share Hospital Payments'' final rule published on December 19, 2008 (73 FR 77904) (and herein referred to as the 2008 DSH final rule) requiring state reports and audits to ensure the appropriate use of Medicaid DSH payments and compliance with the DSH limit imposed at section 1923(g) of the Act. This is the only comprehensive data source for DSH hospitals that identifies hospital-specific DSH payments, hospital-specific uncompensated care costs, and hospital-specific Medicaid utilization in a manner consistent with Medicaid DSH program requirements.

To date, we have received rich, comprehensive audit and reporting data from each state that makes Medicaid DSH payments. To facilitate the provision of high quality data, we provided explicit parameters in the 2008 DSH final rule and associated policy guidance for calculating and reporting data elements. The 2008 DSH final rule included a transition period in which states and auditors could develop and refine audit and reporting techniques. This transition period covered data reported relating to state plan rate years 2005 through 2010. We recognize that the DSH audit and reporting data during this transition period may vary in its quality and accuracy from state to state and have considered utilizing alternative uncompensated cost data and Medicaid utilization data from sources such as the Medicare Form CMS–2552. The DSH audit and reporting data, however, remains the only comprehensive reported data available that is consistent with Medicaid program requirements. States are already required to report this data by the last day of the federal fiscal year ending three years from the Medicaid State plan rate year under audit as required by the 2008 DSH final rule. However, state submitted audit and reporting data is subject to detailed CMS review and may require significant resources to ensure that it is compiled and prepared for use in the proposed DHRM. This means that the data used for the methodology may not be the most recently submitted data, but instead the most recent data available to us in usable form. We have been actively engaged in reviewing state audits and reports to ensure quality and accuracy. Consistent with ongoing efforts to ensure that the reported data is of the highest quality possible as we move through the transition period, we intend to issue additional detailed guidance to states by the end of calendar year (CY) 2013 that would be applicable to audits and reports due to us by the end of CY 2014.

As required by the statute, the DHRM must impose the larger percentage DSH allotment reductions on the states that have the lowest percentages of uninsured individuals. Although other sources of this information could be considered for this purpose, the statute explicitly refers to the use of data from the Census Bureau for determining the percentage of uninsured for each state. We identified and considered two Census Bureau data sources for this purpose, the American Community Survey (ACS); and the Annual Social and Economic Supplement to the Current Population Survey (CPS). In consultation with the Census Bureau, we are proposing to use the data from the ACS for the following reasons. First, the ACS is the largest household survey in the United States; in that regard, the annual sample size for the ACS is over 30 times larger than that for the CPS—about 3 million for the ACS versus 100 thousand for the CPS. The ACS is conducted continuously each month throughout the year, with the sample for each month being roughly 1/12 of the annual total, while the CPS is conducted in the first four months following the end of the survey year. Finally, although the definition of uninsured and insured status is the same for the ACS and the CPS, the CPS considers the respondents as uninsured if they are uninsured at any time during the year whereas the ACS whether the respondent has coverage at the time of the interview, which are conducted at various times throughout the year. For these reasons, and with the recommendation of the Census Bureau, we determined that the ACS is the appropriate source for establishing the percentage of uninsured for each state for purpose of the proposed DHRM.

In addition to Census Bureau data, we considered using various alternative data with different population parameters and/or different definitions of uninsured individuals. We are also considering adjusting the definition of the uninsured for reductions applicable for FY 2016 and beyond reductions through separate rulemaking.

III. Provisions of the Proposed Rule

A. DHRM Overview

The statute requires aggregate annual reduction amounts for FY 2014 through FY 2020 to be reduced through a DHRM designed by the Secretary consistent with the statutorily-established factors. Taking these factors into account for each state, the proposed DHRM would generate a state-specific DSH allotment reduction amount for FY 2014 and FY 2015 for all 50 states and DC. The total of all DSH allotment reduction amounts would equal the aggregate annual reduction amounts identified in the Affordable Care Act for FY 2014 and FY 2015. To determine the effective annual DSH allotment for each state, the state-specific annual DSH allotment reduction amount would be applied to the unreduced DSH allotment amount for its respective state.

We would calculate an unreduced DSH allotment for each state prior to the beginning of each FY, as we do currently. This unreduced allotment is

determined by calculating the allotment in section 1923(f) of the Act prior to the application of the DHRM under section 1923(f)(7) of the Act. The unreduced allotment would serve as the base amount for each state to which the state-specific DSH allotment reduction amount would apply annually. In this proposed rule, we are utilizing estimated unreduced DSH allotments for FY 2014 for illustrative purposes.

We propose to apply the DHRM to the unreduced DSH allotment amount on an annual basis for FY 2014 and FY 2015. Under the DHRM, we consider the five factors identified in the statute to determine each state's annual state-specific annual DSH allotment reduction amount. Limitations on the availability of data relating to some of the five factors affect the calculation and, therefore, we are seeking comment regarding readily available data sources that may be useful.

The proposed DHRM utilizes available data and a series of interacting calculations that result in the identification of state-specific reduction amounts that, when summed, equal the aggregate DSH allotment reduction amount identified by the statute for each applicable year. The proposed DHRM accomplishes this through the following summarized steps:

1. Separate states into two state groups, non-low DSH states and low-DSH states.
2. Proportionately allocate aggregate DSH funding reductions to each of these two state groups based on each state group's total unreduced DSH allotment amount.
3. Apply a Low DSH State Percentage Reduction Factor to adjust each state group's DSH funding reduction amount while maintaining the combined aggregate DSH funding reduction.
4. Divide each state group's DSH allotment reduction amount among three statutorily identified factors, the Uninsured Percentage Factor (UPF), the High Level of Uncompensated Care Factor (HUF), and the High Volume of Medicaid Inpatients Factor (HMF). We are proposing to assign a 33 and ⅓ percent weight to the UPF and a 66 and ⅔ percent combined weight for the two DSH payment targeting factors (a 33 and ⅓ percent weight for the HUF, and a 33 and ⅓ percent weight for the HMF). This weight assignment provides a higher weight to the DSH payment targeting requirements than the UPF. We considered various alternative weight assignments prior to proposing equal weights. We could have assigned a 50 percent weight to the UPF, and a 50 percent combined weight for the two DSH payment targeting factors (25 percent for the HUF and 25 percent for the HMF). This weight assignment would have provided an equal weight to the requirement at 1923(f)(7)(B)(i)(I) of the Act and the requirement at 1923(f)(7)(B)(i)(II) of the Act. We also could have assigned an even lower weight to the uninsured factor than the payment targeting factors, or lower weights to the payment targeting factors than the uninsured factor. We also could have assigned no weight to the uninsured factor or no weight to the targeting factors. We are seeking public comment and input regarding alternate assignments. We also seek comments on how these weights would impact specific hospital types.
5. For each state group, determine state-specific DSH allotment reduction amounts relating to the Uninsured Percentage Factor.
6. For each state group, determine state-specific DSH allotment reduction amounts relating to the High Level of Uncompensated Care Factor.
7. For each state group, determine state-specific DSH allotment reduction amounts relating to the High Volume of Medicaid Inpatients Factor.
8. Apply a section 1115 Budget Neutrality Factor for each qualifying state.
9. Identify the state-specific DSH allotment reduction amount.
10. Subtract each state's state-specific DSH allotment reduction amount from each state's unreduced DSH allotment.

The manner in which each of the five factors are considered and calculated in the proposed DHRM is described in greater detail below.

The proposed DHRM recognizes the variations in the development of DSH allotments among states and the application of the methodology generates a lesser impact on low DSH states. Further, the proposed DHRM is designed to lessen the impact on states that have targeted DSH payments to hospitals that have high volumes of Medicaid inpatients and to hospitals that have high levels of uncompensated care. Concurrently, the proposed DHRM is designed to incentivize states to target current and future DSH payments to hospitals that have higher volumes of Medicaid inpatients and to hospitals that have higher levels of uncompensated care relative to all DSH eligible hospital in a state. The proposed DHRM also takes into account the extent to which the DSH allotment for a state was included in part or in whole in the budget neutrality calculation for a coverage expansion approved under section 1115 as of July 31, 2009 by excluding from DSH allotment reduction the amount of DSH that qualifying states continue to divert specifically for coverage expansion in the budget neutrality calculation. Any amount of DSH diverted for other purposes under the demonstration would still be subject to reduction by automatically assigning qualifying states an average percentage reduction amount for factors for which the state does not have complete and/or relevant DSH payment data.

B. Factor 1—Low DSH Adjustment Factor (LDF)

The first factor considered in the proposed DHRM is the Low DSH Adjustment Factor identified at section 1923(f)(7)(B)(ii) of the Act, which requires that the DHRM impose a smaller percentage reduction on ''low DSH states'' that meet the criterion described in section 1923(f)(5)(B) of the Act in 2003. To qualify as a low DSH state, total expenditures under the state plan for DSH payments for FY 2000, as reported to us as of August 31, 2003, had to have been greater than zero but less than 3 percent of the state's total Medicaid state plan expenditures during the FY. Historically, low DSH states (identified in Table 1) have received lower DSH allotments relative to their total Medicaid expenditures than non-low DSH states.

We propose to apply the Low DSH Adjustment Factor (LDF) by imposing a greater proportion of the annual DSH funding reduction on non-low DSH states. The factor is calculated and applied as follows:

1. Separate states into two groups, non-low DSH states and low-DSH states.
2. Divide each state's unreduced preliminary DSH allotment for the year for which the reduction is calculated by estimated Medicaid service expenditures for that same year. Currently, we create a preliminary DSH allotment based on the estimates available in August of the prior year and we issue a final DSH allotment once the federal FY ends.
3. For each state group, calculate the non-weighted mean of the value calculated in step 2 for states in the group.
4. Divide the average calculated in step 3 for the low DSH state group by the average calculated in step 3 for the non-low DSH state group.
5. Convert this number to a percentage. This percentage is the LDF.
6. Multiply the proportionately allocated DSH funding reductions for the low-DSH state group by the LDF percentage to determine the aggregate DSH reduction amount that would be distributed across the low DSH state group.

7. Subtract the aggregate DSH reduction amount determined in step 6 from the proportionately allocated DSH funding reduction for the low-DSH state group, and add the remainder to the aggregate DSH reduction amount that would be distributed across the non-low DSH state group.

We considered using various alternative proportional relationships to establish the LDF, including the proportion of each state group's annual Medicaid DSH expenditures to total Medicaid expenditures.

C. Factor 2—Uninsured Percentage Factor (UPF)

The second factor considered in the proposed DHRM is the Uninsured Percentage Factor (UPF) identified at section 1923(f)(7)(B)(i)(I) of the Act, which requires that the DHRM impose larger percentage DSH allotment reductions on states that have the lowest percentages of uninsured individuals. The statute also requires that the percentage of uninsured individuals is determined on the basis of data from the Census Bureau, audited hospital cost reports, and other information likely to yield accurate data, during the most recent year for which such data are available.

To determine the percentage of uninsured individuals in each state, the proposed DHRM relies on the total population and uninsured population as identified in the most recent ''1-year estimates'' data available from the ACS conducted by the Census Bureau. The Census Bureau generates ACS ''1-year estimates'' data annually based on a point-in-time survey of approximately 3 million individuals. For purposes of the proposed DHRM, we would utilize the most recent ACS data available at the time of the calculation of the annual DSH allotment reduction amounts.

The UPF, as applied through the proposed DHRM, has the effect of imposing lower relative DSH allotment reductions on states that have the highest percentage of uninsured individuals. The UPF would mitigate the DSH reduction for states with the highest percentage of uninsured individuals.

The proposed UPF is determined separately for each state group (low DSH and non-low DSH) as follows:

1. *Uninsured Value*—Using Bureau of Census data, calculate each state's uninsured value by dividing the total state population by the uninsured in the state. (This is different than the percentage rate of uninsurance; the rate of uninsurance can be obtained by dividing 100 by this number)

2. *Uninsured Allocation Component*—Determine the relative uninsured value for each state compared to other states in the state group by dividing the value in step one by the state group total of step one values. The result should be a percentage, and the total of the percentages for all states in the state group should total 100 percent.

3. *Allocation Weighting Factor*—To ensure that larger and smaller states are given fair weight in the final UPF, divide each state's preliminary unreduced DSH allotment by the sum of all unreduced preliminary DSH allotments in the respective state group to obtain allocation weighting factor, expressed as a percentage. The sum of all weighting factors should equal 100 percent. Then, take this percentage for each state and multiply it by the state's uninsured allocation component determined in step 2. The result is the allocation weighting factor.

4. For each state group, divide each state's allocation weighting factor by the sum of all allocation weighting factors. The resulting percentage is the UPF.

We would determine the UPF portion of the final aggregate DSH allotment reduction allocation for each state by multiplying the state's UPF by the aggregate DSH allotment reduction allocated to the UPF factor for the respective state group. As with the prior factor, we propose to utilize preliminary DSH allotment estimates to develop the DSH reduction factors.

D. Factor 3—High Volume of Medicaid Inpatients Factor (HMF)

The third factor considered in the proposed DHRM is the High Volume of Medicaid Inpatients Factor (HMF) identified at section 1923(f)(7)(B)(i)(II)(aa) of the Act, which requires that the DHRM impose larger percentage DSH allotment reductions on states that do not target DSH payments to hospitals with the highest volumes of Medicaid inpatients. For purposes of the DHRM, the statute defines hospitals with high volumes of Medicaid patients as those defined in section 1923(b)(1)(A) of the Act. These hospitals must meet minimum qualifying requirements at section 1923(d) of the Act and have an MIUR that is at least one standard deviation above the mean MIUR for hospitals receiving Medicaid payments in the state. Every hospital that meets that definition is deemed a disproportionate share hospital and is statutorily required to receive a DSH payment. The HMF, through the proposed DHRM, provides the mitigation of the DSH reduction amount for states that have been targeting and would in the future target DSH payments to these federally deemed hospitals.

States that have been, and continue to, target a large percentage of their DSH payments to hospitals that are federally deemed as a DSH based on their MIUR would receive the lowest reduction amounts relative to their total spending. States that target the largest amounts of DSH payments to hospitals that are not federally deemed based on MIUR would receive larger reduction amounts under this factor. The current DSH allotment amounts are unrelated to the amounts of MIUR-deemed hospitals and their DSH-eligible uncompensated care costs. By basing the HMF reduction on the amounts that states do not target to hospitals with high volumes of Medicaid inpatients, this proposed methodology incentivizes states to target DSH payments to such hospitals.

To ensure that all deemed disproportionate share hospitals receive a required DSH payments, states are already required to determine the mean MIUR for hospitals receiving Medicaid payments in the state and the value of one standard deviation above the mean. This rule proposes to rely on MIUR information for use in the DHRM that CMS intends to collect from states on an annual basis outside of this rule. When a state does not timely submit this separately required MIUR information, for purposes of this factor, CMS will assume that the state has the highest value of one standard deviation above the mean reported among all other states.

The calculation of the HMF would rely on extant data that should be readily available to states. The following data elements are used in the HMF calculation: the preliminary unreduced DSH allotment for each state, the DSH hospital payment amount reported for each DSH in accordance with § 447.299(c)(17), the MIUR for each DSH reported in accordance with § 447.299(c)(3), and the value of one standard deviation above the mean MIUR for hospitals receiving Medicaid payments in the state reported separately.

The proposed HMF is a state-specific percentage that is calculated separately for each state group (low DSH and non-low DSH) as follows:

1. For each state, classify each disproportionate share hospital that has an MIUR at least one standard deviation above the mean MIUR for hospitals receiving Medicaid payments in the state as a High Medicaid Volume hospital.

2. For each state, determine the amount of DSH payments to non-High Medicaid Volume DSH hospitals. This

data element should come from the most recently submitted and accepted DSH audit template.

3. For each state, determine a percentage by dividing the state's total DSH payments made to non-High Medicaid Volume hospitals by the aggregate amount of DSH payments made to non-High Medicaid Volume hospitals for the entire state group.

4. The result of step 3 is the HMF.

We would determine each state's HMF reduction amount by applying the HMF percentage to the aggregate reduction amount allocated to this factor for each state group.

As a result of this methodology, there are a number of interactions that may occur for states among DSH payment methodologies, DSH allotments, and DSH allotment reductions. Most of these scenarios work in concert with this factor's established reduction relationship. For example, if a state paid out its entire DSH allotment to hospitals with high volumes of Medicaid inpatients, it would receive no reduction associated with this factor because all DSH payments were made only to hospitals that qualify as high volume. The results of this scenario would be consistent with the methodology because the state is incentivized to target DSH payments to high Medicaid volume hospitals.

Another example is a state that makes DSH payments up to the hospital-specific DSH limit to all hospitals with high Medicaid volume but also uses its remaining allotment to make DSH payments to hospitals that do not qualify as high volume. In this example, the state would receive a reduction under this factor based on the amount of DSH payments it made to non-high Medicaid volume hospitals. Though the state targeted DSH payments to hospitals with high Medicaid volume, the existing size of its DSH allotment permitted it to make DSH payments to hospitals that did not meet the statutory definition of high Medicaid volume. In that situation, this allotment reduction would effectively reduce a state's existing DSH allotment to the extent that the allotment exceeded the maximum amount that the state could pay to hospitals that are high Medicaid volume. The resulting HMF reduction would be greater for states with DSH allotments large enough to pay significant amounts to non-high Medicaid volume hospitals. This ensures that states target DSH payments to high Medicaid volume hospitals and distribute the reductions in such a way as to promote the ability of all states to provide DSH funds to high Medicaid volume hospitals.

We would continue to analyze the proposed DHRM and comments to the proposed rule to ensure that the DHRM is effective in tying the level of DSH reductions to the targeting of DSH payments to high Medicaid volume hospitals.

E. Factor 4—High Level of Uncompensated Care Factor (HUF)

The fourth factor considered in the DHRM is the HUF identified at section 1923(f)(7)(B)(i)(II)(bb) of the Act, which requires that the DHRM impose larger percentage DSH allotment reductions on states that do not target DSH payments on hospitals with high levels of uncompensated care. We are proposing to rely on the existing statutory definition of uncompensated care cost used in determining the hospital-specific limit on FFP for DSH payments.

Each state must develop a methodology to compute this hospital-specific limit for each DSH hospital in the state. As defined in section 1923(g)(1) of the Act, the state's methodology must calculate for each hospital, for each FY, the difference between the costs incurred by that hospital for furnishing inpatient hospital and outpatient hospital services during the applicable state FY to Medicaid individuals and individuals who have no health insurance or other source of third party coverage for the inpatient hospital and outpatient hospital services they receive, less all applicable revenues for these hospital services. This difference, if any, between incurred inpatient hospital and outpatient hospital costs and associated revenues is considered a hospital's uncompensated care cost limit, or hospital-specific DSH limit.

For purposes of this rule, we are proposing to rely on this definition of uncompensated cost for the calculation of the HUF, as reported by states on the most recent available DSH audit and reporting data. For the proposed DHRM, hospitals with high levels of uncompensated care are defined based on a comparison with other Medicaid DSH hospitals in their state. Any hospital that exceeds the mean ratio of uncompensated care costs to total Medicaid and uninsured inpatient and outpatient hospital service costs within its state is considered a hospital with a high level of uncompensated care. This data is consistent with existing Medicaid DSH program definition of uncompensated care and is readily available to states and us.

The following data elements are used in the HUF calculation:

- The preliminary unreduced DSH allotment for each state;
- DSH hospital payment amounts reported for each DSH in accordance with § 447.299(c)(17);
- Uncompensated care cost amounts reported for each DSH in accordance with § 447.299(c)(16);
- Total Medicaid cost amounts reported for each DSH in accordance with § 447.299(c)(10); and
- Total uninsured cost amounts reported for each DSH in accordance with § 447.299(c)(14).

The statute also requires that uncompensated care used in this factor of the DHRM exclude bad debt. The proposed rule relies on the uncompensated care cost data derived from Medicaid DSH audit and reporting required by section 1923(f) of the Act and implementing regulations. This uncompensated care data excludes bad debt, including unpaid co-pays and deductibles, associated with individuals with a source of third party coverage for the service received during the year.

The HUF is a state-specific percentage that is calculated separately for each state group (low DSH and non-low DSH) as follows:

1. Determine each disproportionate share hospital's Uncompensated Care Level by dividing its uncompensated care cost by the sum of its total Medicaid cost and its total uninsured cost. This data element would come from the most recently submitted and accepted DSH audit template.

2. For each state, calculate the weighted mean Uncompensated Care Level.

3. Identify all hospitals that meet or exceed the mean Uncompensated Care Level as High Uncompensated Care Level hospitals. We also considered identifying a metric higher than the mean for purposes of identifying hospitals as High Uncompensated Care Level hospitals and are soliciting comments on this alternative.

4. For each state, determine the amount of DSH payments to non-High Uncompensated Care Level hospitals.

5. For each state, determine a percentage by dividing the state's total DSH payments made to non-High Uncompensated Care Level hospitals by the aggregate amount of DSH payments made to non-High Uncompensated Care Level hospitals for the entire state group. The result is the HUF.

We would determine each state's HUF reduction amount by applying the HUF percentage to the aggregate reduction amount allocated to this factor for each state group. Similar to the HMF, this methodology may produce a number of interactions that could occur for states among DSH payment methodologies, DSH allotments, and DSH allotment

reductions. Most of these interactions work in concert with the intent of this factor's established reduction relationship. However, we have identified some potential scenarios where the interactions may be inconsistent with the methodology. For example, it is possible that a hospital may not be considered to have a high level of uncompensated care even though it provides a higher percentage of services to Medicaid and uninsured individuals and has a greater total qualifying uncompensated care costs than another hospital that does qualify as having a high level of uncompensated care. Specifically, Hospital A has $20 million in total hospital costs, $11 million in DSH-eligible Medicaid and uninsured costs, and $5 million in uncompensated care cost. Hospital B has $50 million in total hospital costs, $2 million in DSH-eligible Medicaid and uninsured costs, and $1 million in uncompensated care cost. Assuming the weighted mean uncompensated care cost level in the state is 50 percent, Hospital B would be considered to have high level of uncompensated care and Hospital A would not. Given that Hospital A has 5 times the total uncompensated care of Hospital B and serves a much higher percentage of Medicaid and uninsured individuals, the results of this scenario are counter to the intent of the methodology.

This scenario exists because the proposed formula does not take into account total hospital costs due to extant data limitations. To address this concern, we are proposing to modify DSH reporting requirements to collect total hospital cost from Medicare cost report data for all DSH hospitals. Through separately issued rulemaking for FY 2016 and thereafter, we intend to substitute total cost for the denominator in step one of the HUF calculation above. Since total cost is unavailable at this time, we are seeking comment on alternatives to the use of total uncompensated care cost as the denominator to alleviate this data issue.

We would continue to analyze the proposed DHRM and comments to the proposed rule to ensure that the DHRM is effective in tying the level of DSH reductions to the targeting of DSH payments to hospitals with high levels of uncompensated care. We believe that the proposed methodology, in using the mean uncompensated care cost level as the measure to identify hospitals with high levels of uncompensated care, captures the best balance in tying the level of DSH reductions to the targeting of DSH payments to such high level hospitals. Understanding potential data limitations and that the proposed methodology does not precisely distinguish how states direct DSH payments among hospitals that are identified as at or above the mean uncompensated care, we solicit comments on alternative methodologies regarding state targeting of DSH payments to hospitals with high levels of uncompensated care.

F. Factor 5—Section 1115 Budget Neutrality Factor (BNF)

The statute requires that we take into account the extent to which a 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. Prior to the implementation of this proposed rule, these states possess full annual DSH allotments as calculated under section 1923(f) of the Act. Under an approved section 1115 demonstration, however, the states may have limited authority to make DSH payments under section 1923 of the Act because all or a portion of their DSH allotment was included in the budget neutrality calculation for a coverage expansion under an approved section 1115 demonstration or to fund uncompensated care pools and/or safety net care pools. For applicable states, DSH payments under section 1923 of the Act are limited to the DSH allotment calculated under section 1923(f) of the Act less the allotment amount included in the budget neutrality calculation. If a state's entire DSH allotment is included in the budget neutrality calculation, it would have no available DSH funds with which to make DSH payments under section 1923 of the Act for the period of the demonstration.

Consistent with the statute, for states that include DSH allotment in budget neutrality calculations for coverage expansion under an approved section 1115 demonstration as of July 31, 2009, we propose to exclude from DSH allotment reduction, for the HMF and the HUF factors, the amount of DSH allotment that each state currently continues to divert specifically for coverage expansion in the budget neutrality calculation. Amounts of DSH allotment included in budget neutrality calculations for non-coverage expansion purposes under approved demonstrations would still be subject to reduction. Uncompensated care pools and safety net care pools are considered non-coverage expansion purposes. For section 1115 demonstrations not approved as of July 31, 2009, any DSH allotment amounts included in budget neutrality calculations, whether for coverage expansion or otherwise, under a later approval would also be subject to reduction.

We are proposing to determine for each reduction year if any portion of a state's DSH allotment qualifies for consideration under this factor. To qualify annually, CMS and the state would have to have included its DSH allotment in the budget neutrality calculation for a coverage expansion that was approved under section 1115 as of July 31, 2009, and would have to continue to do so at the time that reduction amounts are calculated for each FY.

The proposed DHRM would take into account the extent to which the DSH allotment for a state was included in the budget neutrality calculation approved under section 1115 as of July 31, 2009 by excluding amounts diverted specifically for a coverage expansion and automatically assigning qualifying states an average reduction amount (based on the state group) for any DSH allotment diverted for non-coverage expansion purposes and any amounts diverted for coverage expansion if the section 1115 demonstration was or is approved after July 31, 2009. DSH allotment reductions relating to two DHRM factors (the HUF and the HMF) are determined based on how states target DSH payments to certain hospitals. Since states qualifying under the budget neutrality provision would have limited or no relevant data for these two factors, we would be unable to evaluate how they spent the portion of their DSH allotment that was diverted for non-coverage expansion. Accordingly, we are proposing to maintain the HUF and HMF formula for DSH payments for which qualifying states would have available data. Because we would not have DSH payment data for DSH allotment amounts diverted for non-coverage expansion, we are proposing to assign average HUF and HMF reduction percentages for the portion of their DSH allotment that they were unable to use to target payments to disproportionate share hospitals. Instead of assigning the average percentage reduction to non-qualifying amounts, we considered using various alternative percentages. Additionally, for qualifying allotment amounts diverted specifically for coverage expansion, we considered applying the BNF reduction exclusion to the UPF in addition to the HMF and HUF. We are seeking comment regarding the use of different percentages for the reductions to non-qualifying diversion amounts and regarding alternative BNF methodologies that may prove preferable alternatives.

We recognize that the goal of the expanded coverage and/or payment of uncompensated care is directly addressed by the statute. The goal is addressed by statute by offering states other, non-DSH funds for such expansions, thus limiting the need for the diverted DSH under demonstrations. Accordingly, the group of states affected by this factor today may change at a later time, depending on how their coverage continues to be financed. In addition, based on changes in the health coverage landscape, we will reevaluate this policy in future rulemaking.

G. Illustration of DSH Health Reform Methodology (DHRM)

Table 1 and the values contained therein are provided only for purposes of illustrating the application of the DHRM and the associated DSH reduction factors described in this proposed rule to determine each states' DSH allotment reduction for FY 2014. Note that these values do not represent the final DSH reduction amounts for FY 2014.

BILLING CODE 4120–01–P

TABLE 1:

*FOR ILLUSTRATION PURPOSES ONLY - FY 2014 DSH HEALTH REFORM METHODOLOGY

		ILLUSTRATIVE DSH Reduction Factor Weighting Allocation*			
	Total Reduction:	Uninsured Factor UPF	Hi Volume Factor HMF	High Level Factor HUF	TOTAL
		33.3%	33.3%	33.3%	100.0%
	Total Reg. DSH Reduction:	$164,588,883	$164,588,883	$164,588,883	$493,766,649
LOW DSH Adj. Factor	Total Low DSH Reduction:	$2,077,784	$2,077,784	$2,077,784	$6,233,351
27.97%	TOTAL:	$166,666,667	$166,666,667	$166,666,667	$500,000,000

A	B	C	D	E	F	G	H
STATE	Unreduced FY 2014 DSH Allotment (Estimate)*	Reduction Based on UPF Uninsured Factor* Col J, UPF WS	Reduction Based on HMF High Volume Factor* Col O , HMF WS	Reduction Based On HUF High Level Factor* Col O, HUC WS	Total Reduction* C + D + E	Reduction Amount As Percentage of Unreduced DSH Allotment* F/B	FY 2014 Reduced Allotment* B - F
Alabama	$327,306,706	$4,450,693	$6,450,832	$5,965,703	$16,867,229	5.15%	$310,439,477
Arkansas	$107,771,720	$1,225,578	$2,320,621	$4,144,131	$7,690,330	7.14%	$100,081,389
California	$1,166,861,709	$12,496,019	$19,339,288	$787,771	$32,623,078	2.80%	$1,134,238,632
Colorado	$98,458,114	$1,227,835	$953,242	$3,262,103	$5,443,181	5.53%	$93,014,933
Connecticut	$212,882,410	$4,646,855	$4,209,148	$4,474,769	$13,330,772	6.26%	$199,551,638
District of Columbia /1	$65,195,237	$1,703,076	$463,119	$844,089	$3,010,283	4.62%	$62,184,954
Florida	$212,882,410	$1,987,539	$2,887,967	$5,215,949	$10,091,455	4.74%	$202,790,954
Georgia	$286,060,738	$2,882,526	$3,130,957	$5,060,927	$11,074,410	3.87%	$274,986,328
Illinois	$228,848,590	$3,298,528	$3,645,082	$3,899,617	$10,843,227	4.74%	$218,005,363
Indiana	$227,518,076	$3,045,530	$3,282,746	$1,280,446	$7,608,722	3.34%	$219,909,354
Kansas	$43,906,997	$627,702	$922,471	$683,318	$2,233,492	5.09%	$41,673,505
Kentucky	$154,339,747	$2,009,128	$2,429,559	$2,068,748	$6,507,436	4.22%	$147,832,311
Louisiana	$731,960,000	$8,157,359	$12,281,637	$4,906,454	$25,345,450	3.46%	$706,614,550

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LOW DSH Adj. Factor	Total Low DSH Reduction:	$2,077,784	$2,077,784	$2,077,784	$6,233,351
27.97%	TOTAL:	$166,666,667	$166,666,667	$166,666,667	$500,000,000

A	B	C	D	E	F	G	H
STATE	Unreduced FY 2014 DSH Allotment (Estimate)*	Reduction Based on UPF Uninsured Factor*	Reduction Based on HMF High Volume Factor*	Reduction Based On HUF High Level Factor*	Total Reduction*	Reduction Amount As Percentage of Unreduced DSH Allotment*	FY 2014 Reduced Allotment*
		Col J, UPF WS	Col O , HMF WS	Col O, HUC WS	C + D + E	F/B	B - F
Maine /1	$111,763,265	$2,189,425	$1,324,174	$2,413,463	$5,927,063	5.30%	$105,836,203
Maryland	$81,161,419	$1,430,089	$1,639,479	$1,726,902	$4,796,470	5.91%	$76,364,948
Massachusetts /1	$324,645,675	$14,612,915	$1,031,865	$1,076,550	$16,721,329	5.15%	$307,924,346
Michigan	$282,069,193	$4,528,369	$3,256,081	$5,661,017	$13,445,466	4.77%	$268,623,727
Mississippi	$162,322,837	$1,771,408	$1,928,694	$715,775	$4,415,876	2.72%	$157,906,961
Missouri	$504,265,209	$7,606,111	$7,179,807	$11,117,502	$25,903,421	5.14%	$478,361,788
Nevada	$49,229,057	$432,077	$226,353	$258,039	$916,469	1.86%	$48,312,588
New Hampshire	$170,410,795	$3,039,010	$2,714,290	$2,903,827	$8,657,127	5.08%	$161,753,668
New Jersey	$685,215,257	$10,273,222	$9,989,871	$9,086,087	$29,349,180	4.28%	$655,866,077
New York	$1,709,711,855	$28,517,869	$17,330,775	$19,682,882	$65,531,526	3.83%	$1,644,180,330
North Carolina	$314,001,555	$3,717,078	$6,628,232	$3,952,052	$14,297,361	4.55%	$299,704,194
Ohio	$432,417,395	$6,970,234	$6,496,637	$9,942,522	$23,409,393	5.41%	$409,008,002
Pennsylvania	$597,401,262	$11,667,972	$9,874,704	$12,323,972	$33,866,647	5.67%	$563,534,615
Rhode Island	$69,186,783	$1,128,516	$1,332,369	$1,002,242	$3,463,128	5.01%	$65,723,655
South Carolina	$348,594,946	$3,947,977	$5,769,094	$3,995,248	$13,712,319	3.93%	$334,882,628

*FOR ILLUSTRATION PURPOSES ONLY - FY 2014 DSH HEALTH REFORM METHODOLOGY

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		33.3%	33.3%	33.3%	100.0%
	Total Reg. DSH Reduction:	$164,588,883	$164,588,883	$164,588,883	$493,766,649
LOW DSH Adj. Factor	Total Low DSH Reduction:	$2,077,784	$2,077,784	$2,077,784	$6,233,351
27.97%	TOTAL:	$166,666,667	$166,666,667	$166,666,667	$500,000,000

A	B	C	D	E	F	G	H
STATE	Unreduced FY 2014 DSH Allotment (Estimate)*	Reduction Based on UPF Uninsured Factor*	Reduction Based on HMF High Volume Factor*	Reduction Based On HUF High Level Factor*	Total Reduction*	Reduction Amount As Percentage of Unreduced DSH Allotment*	FY 2014 Reduced Allotment*
		Col J, UPF WS	Col O , HMF WS	Col O, HUC WS	C + D + E	F/B	B - F
Tennessee	$54,007,000	$746,901	$860,219	$920,288	$2,527,408	4.68%	$51,479,592
Texas	$1,017,844,022	$8,522,124	$18,255,733	$29,359,012	$56,136,869	5.52%	$961,707,154
Vermont	$23,949,271	$590,875	$434,558	$276,383	$1,301,816	5.44%	$22,647,455
Virginia	$93,250,559	$1,416,841	$1,718,425	$1,230,356	$4,365,622	4.68%	$88,884,936
Washington	$196,916,230	$2,744,350	$3,136,466	$3,355,484	$9,236,300	4.69%	$187,679,929
West Virginia	$71,847,813	$977,152	$1,144,386	$995,254	$3,116,792	4.34%	$68,731,021
Total Regular DSH States	$11,164,203,854	$164,588,883	$164,588,883	$164,588,883	$493,766,649	4.42%	$10,670,437,205
LOW DSH STATES							
Alaska	$21,681,747	$51,937	$173,996	$87,475	$313,408	1.45%	$21,368,340
Arizona	$45,916,375	$129,368	$129,235	$42,155	$300,758	0.66%	$45,615,618
Delaware	$9,636,331	$47,282	$0	$0	$47,282	0.49%	$9,589,049
Hawaii	$10,393,800	$62,676	$70,765	$104,311	$237,752	2.29%	$10,156,048
Idaho	$17,496,274	$46,880	$111,960	$50,217	$209,057	1.19%	$17,287,217

***FOR ILLUSTRATION PURPOSES ONLY - FY 2014 DSH HEALTH REFORM METHODOLOGY**

		ILLUSTRATIVE DSH Reduction Factor Weighting Allocation*			
	Total Reduction:	Uninsured Factor UPF	Hi Volume Factor HMF	High Level Factor HUF	TOTAL
		33.3%	33.3%	33.3%	100.0%
	Total Reg. DSH Reduction:	$164,588,883	$164,588,883	$164,588,883	$493,766,649
LOW DSH Adj. Factor	Total Low DSH Reduction:	$2,077,784	$2,077,784	$2,077,784	$6,233,351
27.97%	TOTAL:	$166,666,667	$166,666,667	$166,666,667	$500,000,000

A	B	C	D	E	F	G	H
STATE	Unreduced FY 2014 DSH Allotment (Estimate)*	Reduction Based on UPF Uninsured Factor*	Reduction Based on HMF High Volume Factor*	Reduction Based On HUF High Level Factor*	Total Reduction*	Reduction Amount As Percentage of Unreduced DSH Allotment*	FY 2014 Reduced Allotment*
		Col J, UPF WS	Col O , HMF WS	Col O, HUC WS	C + D + E	F/B	B - F
Iowa	$41,917,760	$214,084	$75,590	$115,863	$405,536	0.97%	$41,512,224
Minnesota	$79,499,739	$416,944	$257,348	$623,061	$1,297,353	1.63%	$78,202,386
Montana	$12,081,903	$33,172	$68,731	$89,562	$191,465	1.58%	$11,890,437
Nebraska	$30,120,968	$124,314	$238,785	$249,312	$612,411	2.03%	$29,508,557
New Mexico	$21,681,747	$52,589	$168,797	$52,617	$274,003	1.26%	$21,407,744
North Dakota	$10,167,243	$49,497	$60,321	$13,300	$123,117	1.21%	$10,044,126
Oklahoma	$38,545,326	$97,193	$110,492	$391,760	$599,445	1.56%	$37,945,882
Oregon	$48,181,658	$133,619	$381,129	$9,220	$523,968	1.09%	$47,657,690
South Dakota	$11,756,055	$45,126	$70,228	$36,545	$151,899	1.29%	$11,604,156
Utah	$20,881,618	$64,735	$159,292	$211,938	$435,965	2.09%	$20,445,653
Wisconsin /1	$100,621,875	$507,599	$0	$0	$507,599	0.50%	$100,114,275
Wyoming	$240,907	$768	$1,115	$448	$2,331	0.97%	$238,576
Total Low DSH States	**$520,821,329**	**$2,077,784**	**$2,077,784**	**$2,077,784**	**$6,233,351**	**1.20%**	**$514,587,978**

*FOR ILLUSTRATION PURPOSES ONLY - FY 2014 DSH HEALTH REFORM METHODOLOGY

		ILLUSTRATIVE DSH Reduction Factor Weighting Allocation*			
	Total Reduction:	Uninsured Factor UPF	Hi Volume Factor HMF	High Level Factor HUF	TOTAL
		33.3%	33.3%	33.3%	100.0%
	Total Reg. DSH Reduction:	$164,588,883	$164,588,883	$164,588,883	$493,766,649
LOW DSH Adj. Factor	Total Low DSH Reduction:	$2,077,784	$2,077,784	$2,077,784	$6,233,351
27.97%	TOTAL:	$166,666,667	$166,666,667	$166,666,667	$500,000,000

A	B	C	D	E	F	G	H
STATE	Unreduced FY 2014 DSH Allotment (Estimate)*	Reduction Based on UPF Uninsured Factor*	Reduction Based on HMF High Volume Factor*	Reduction Based On HUF High Level Factor*	Total Reduction*	Reduction Amount As Percentage of Unreduced DSH Allotment*	FY 2014 Reduced Allotment*
		Col J, UPF WS	Col O , HMF WS	Col O, HUC WS	C + D + E	F/B	B - F
National Total	$11,685,025,183	$166,666,667	$166,666,667	$166,666,667	$500,000,000	4.28%	$11,185,025,183

Notes:
*All of the values on this chart are only for purposes of illustrating the DSH Health Reform Methodology (DHRM)
/1 Potential DSH Diversion State

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IV. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, 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. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 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.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

To derive average costs, we used data from the U.S. Bureau of Labor Statistics for all salary estimates. The salary estimates include the cost of fringe benefits, based on the December 2012 Employer Costs for Employee Compensation report by the Bureau.

We are soliciting public comment on each of the section 3506(c)(2)(A)-required issues for the following information collection requirements (ICRs):

ICRs Regarding Reporting Requirements (§ 447.299)

Beginning with each state's Medicaid state plan rate year 2005, for each Medicaid state plan rate year, the state must submit to CMS, at the same time as it submits the completed DSH audit required under § 455.204, the following information for each DSH hospital to which the state made a DSH payment in order to permit verification of the appropriateness of such payments.

The ongoing burden associated with the requirements under § 447.299 is the time and effort it would take each of the 50 state Medicaid Programs and the District of Columbia to complete the annual Medicaid DSH reporting requirements. Based on the information proposed in this rule, we estimate that it would take an additional 4 hours per state (from 38 approved hr to 42 total hr) to complete the DSH reporting spreadsheets. Consequently, we also estimate an additional 204 (4 × 51) annual hours for all states and the District of Columbia (or 2,142 total hr) and an additional cost of $10,404 (or $85,434 total).

In deriving these figures, we used the following hourly labor rates and estimated the time to complete each task: $51.00/hr and an additional 102 hr (1,071 total hours) for management and professional staff to review and prepare reports, and $28.77/hr and an additional 102 hr (1,071 total hours) for office staff to prepare the reports.

The preceding requirements and burden estimates will be added to the existing PRA-related requirements and burden estimates that have been approved by OMB under OCN 0938–0746 (CMS–R–266). The revised total burden estimates amount to: 51 annual respondents, 51 annual responses, and 2,142 annual hours.

Submission of PRA-Related Comments

We have submitted a copy of this proposed rule to OMB for its review of the rule's information collection and recordkeeping requirements. These requirements are not effective until they have been approved by the OMB.

To obtain copies of the supporting statement and any related forms for the proposed paperwork collections referenced above, access CMS' Web site at *http://www.cms.hhs.gov/Paperwork@cms.hhs.gov,* or call the Reports Clearance Office at 410–786–1326.

We invite public comments on these potential information collection requirements. If you comment on these information collection and recordkeeping requirements, please do either of the following:

1. Submit your comments electronically as specified in the **ADDRESSES** section of this proposed rule; or
2. Submit your comments to the Office of Information and Regulatory Affairs, Office of Management and Budget, Attention: CMS Desk Officer, (CMS–2367–P) Fax: (202) 395–6974; or Email: *OIRA_submission@omb.eop.gov.*

V. Response to Comments

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

VI. Regulatory Impact Statement

A. Statement of Need

The Affordable Care Act amended the Act by requiring aggregate reductions to state Medicaid DSH allotments annually from FY 2014 through FY 2020. This proposed rule delineates the DHRM to implement the annual reductions for FY 2014 and FY 2015.

B. Overall Impact

We have examined the impact of this rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), the Regulatory Flexibility Act (RFA) (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). This rule has been designated an ''economically significant'' rule measured by the $100 million threshold, under section 3(f)(1) of Executive Order 12866. Accordingly, we have prepared a Regulatory Impact Analysis (RIA) that, to the best of our ability, presents the costs and benefits of the rulemaking. In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

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 2013, that threshold is approximately $141 million. This final rule would not mandate any requirements for State, local, or tribal governments, nor would it affect private sector costs.

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

The RFA requires agencies to analyze options for regulatory relief of small entities. For purposes of the RFA, small

entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $7.0 million to $34.5 million in any 1 year. Individuals and states are not included in the definition of a small entity.

We are not preparing an analysis for the RFA because we have determined, and the Secretary certifies, that this proposed rule would not have a significant economic impact on a substantial number of small entities.

In addition, section 1102(b) of the Act requires us to prepare 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 603 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area for Medicare payment regulations and has fewer than 100 beds. We are not preparing an analysis for section 1102(b) of the Act because we have determined, and the Secretary certifies, that this proposed rule would not have a significant impact on the operations of a substantial number of small rural hospitals.

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

This proposed rule may be of interest to, and affect, American Indians/Alaska Natives. Therefore, we plan to consult with Tribes during the comment period and prior to publishing a final rule.

C. Anticipated Effects

1. Effects on State Medicaid Programs

We anticipate, effective for FY 2014, that the proposed DSH allotment reductions would have a direct effect on the ability for some or all states to maintain state-wide Medicaid DSH payments at FY 2013 levels. Federal share DSH allotments, which are published by CMS in an annual **Federal Register** notice, limit the amount of federal financial participation (FFP) in the aggregate that states can pay annually in DSH payments to hospitals. This proposed rule would reduce state DSH allotment amounts and would, therefore, limit the states' ability to make DSH payments and claim FFP for DSH payments at FY 2013 levels. By statute, the rule would reduce state DSH allotments by $500,000,000 for FY 2014 and $600,000,000 for FY 2015. We anticipate that the rule would reduce total federal financial participation claimed by states by similar amounts, although it may not equal the exact amount of the allotment reductions. Due to the complexity of the interaction among the proposed DHRM methodology, state DSH allotments, DHRM data, future state DSH payment levels and methodologies for FY 2014 and FY 2015, we cannot provide a specific estimate of the total federal financial impact for each year.

The proposed rule utilizes a DHRM that would mitigate the negative impact on states that continue to have high percentages of uninsured and are targeting DSH payments on hospitals that have a high volume of Medicaid inpatient and on hospitals with high levels of uncompensated care.

2. Effects on Providers

We anticipate that the final rule would affect certain providers through the reduction of state DSH payments. We cannot, however, estimate the impact on individual providers or groups of providers. This proposed 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 statute and regulations. States would retain the ability to preserve existing DSH payment methodologies or to propose modified methodologies by submitting state plan amendments to us. Some states may determine that implementing a proportional reduction in DSH payments for all qualifying hospitals is the preferred method to account for the reduced allotment. Alternatively, states could determine that it the best action is to propose a methodology that would direct DSH payments reductions to hospitals that do not have high Medicaid volume and do not have high levels of uncompensated care. Regardless, the rule incentivizes states to target DSH payments to hospitals that are most in need of Medicaid DSH funding based on their serving a high volume of Medicaid inpatient and having a high level of uncompensated care.

This proposed rule also does not affect the calculation of the hospital-specific DSH limit established at section 1923(g) of the Act. This hospital-specific limit requires that Medicaid DSH payments to a qualifying hospital not exceed the costs incurred by that hospital for providing inpatient and outpatient hospital services furnished during the year to Medicaid patients and individuals who have no health insurance or other source of third party coverage for the services provided during the year, less applicable revenues for those services.

Although this rule would reduce state DSH allotments, the management of the reduced allotments still largely remains with the states. Given that states would retain the same flexibility to design DSH payment methodologies under the state plan and that individual hospital DSH payment limits would not be reduced, we cannot predict whether and how states would exercise their flexibility in setting DSH payments to account for their reduced DSH allotment and how this would affect individual providers or specific groups of providers.

D. Alternatives Considered

The Affordable Care Act specifies the annual DSH allotment reduction amounts for FY 2014 and FY 2015. Therefore, we were unable to consider alternative reduction amounts. Alternatives to the proposed DHRM methodology are discussed through the preceding section of this rule.

E. Accounting Statement and Table

As required by OMB Circular A–4 (available at *http://www.whitehouse.gov/omb/circulars_a004_a-4/*), we have prepared an accounting statement table showing the classification of the impacts associated with implementation of this proposed rule.

TABLE 2—ACCOUNTING STATEMENT

Category	Estimates	Units		
		Year dollar	Discount rate	Period covered
Transfers:				
Annualized Reductions in Disproportionate Share Hospital Allotment (in millions)	−548	2013	7%	2014–2015
	−549	2013	3%	2014–2015
From Whom to Whom	Federal Government to the States due to assumed reduced number of uninsured and uncompensated care.			

List of Subjects in 42 CFR Part 447

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

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

PART 447—PAYMENTS FOR SERVICES

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

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

Subpart E—Payment Adjustments for Hospitals That Serve a Disproportionate Number of Low-Income Patients

■ 2. Section 447.294 is added to read as follows:

§ 447.294 Medicaid disproportionate share hospital (DSH) allotment reductions for Federal fiscal year 2014 and Federal fiscal year 2015.

(a) *Basis and purpose.* This section sets forth the DSH health reform methodology (DHRM) for calculating State-specific annual DSH allotment reductions from Federal fiscal year 2014 and Federal fiscal year 2015 as required under section 1923(f) of the Act.

(b) *Definitions.* For purposes of this section—

Aggregate DSH allotment reductions mean the amounts identified in section 1923(f)(7)(A)(ii) of the Act.

Budget neutrality factor (BNF) is a factor incorporated in the DHRM that takes into account 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 as of July 31, 2009.

DSH payment means the amount reported in accordance with § 447.299(c)(17).

Effective DSH allotment means the amount of DSH allotment determined by subtracting the State-specific DSH allotment from a State's unreduced DSH allotment.

High level of uncompensated care factor (HUF) is a factor incorporated in the DHRM that results in larger percentage DSH allotment reduction for States that do not target DSH payments on hospitals with high levels of uncompensated care.

High Medicaid volume hospital means a disproportionate share hospital that has an MIUR at least one standard deviation above the mean MIUR for hospitals receiving Medicaid payments in the State.

High uncompensated care hospital means a hospital that exceeds the mean ratio of uncompensated care costs to total Medicaid and uninsured inpatient and outpatient hospital service costs for all disproportionate share hospitals within a state.

High volume of Medicaid inpatients factor (HMF) is a factor incorporated in the DHRM that results in larger percentage DSH allotment reduction for States that do not target DSH payments on hospitals with high volumes of Medicaid inpatients.

Hospital with high volumes of Medicaid inpatients means a disproportionate share hospital that meets the requirements of section 1923(b)(1)(A) of the Act.

Low DSH adjustment factor (LDF) is a factor incorporated in the DHRM that results in a smaller percentage DSH allotment reduction on low DSH States.

Low DSH State means a State that meets the criterion described in section 1923(f)(5)(B) of the Act.

Mean HUF reduction percentage is the mean of each State within a State group's quotient of its HUF reduction dividing by its unreduced DSH allotment.

Medicaid inpatient utilization rate (MIUR) means the rate defined in section 1923(b)(2) of the Act.

Non-high Medicaid volume hospital means a disproportionate share hospitals that does not meet the requirements of section 1923(b)(1)(A) of the Act.

State group means similarly situated States that are collectively identified by DHRM.

State-specific DSH allotment reduction means the amount of annual DSH allotment reduction for a particular State as determined by the DHRM.

Total Medicaid cost means the amount reported in accordance with § 447.299(c)(10).

Total population means the 1-year estimates data of the total non-institutionalized population identified by United States Census Bureau's American Community Survey.

Total uninsured cost means the amount reported for each DSH in accordance with § 447.299(c)(14).

Uncompensated care cost means the amount reported in accordance with § 447.299(c)(16).

Uncompensated care level means a hospital's uncompensated care cost divided by the sum of its total Medicaid cost and its total uninsured cost.

Uninsured percentage factor (UPF) is a factor incorporated in the DHRM that results in larger percentage DSH allotment reductions for States that have the lowest percentages of uninsured individuals.

Uninsured population means 1-year estimates data of the number of uninsured identified by United States Census Bureau's American Community Survey.

Unreduced DSH allotment means the DSH allotment calculated under section 1923(f) of the Act prior to annual reductions under this section.

(c) *Aggregate DSH allotment reduction amounts.* The aggregate DSH allotment reduction amounts are as provided in section 1923(f)(7)(A)(ii) of the Act.

(d) *State data submission requirements.* States are required to submit the mean MIUR, determined in accordance with section 1923(b)(1)(A) of the Act, for all hospitals receiving Medicaid payments in the State and the

value of one standard deviation above such mean. The State must provide this data to CMS by June 30 of each year identified in paragraph (c) of this section.

(e) *DHRM methodology.* Section 1923(f)(7) of the Act requires aggregate annual reduction amounts for FY 2014 and FY 2015 to be reduced through the DHRM. The DHRM is calculated on an annual basis based on the most recent data available to CMS at the time of the calculation. The DHRM is determined as follows:

(1) *Establishing State groups.* For each FY, CMS will separate low-DSH States and non-low DSH states into distinct State groups.

(2) *Aggregate DSH allotment reduction allocation.* CMS will allocate a portion of the aggregate DSH allotment reductions to each State group by the following:

(i) Dividing the sum of each State group's preliminary unreduced DSH allotments by the sum of both State groups' preliminary unreduced DSH allotment amounts to determine a percentage.

(ii) Multiplying the value of paragraph (e)(2)(i) of this section by the aggregate DSH allotment reduction amount under paragraph (c) of this section for the applicable fiscal year.

(iii) Applying the low DSH adjustment factor under paragraph (e)(3) of this section.

(3) *Low DSH adjustment factor (LDF) calculation.* CMS will calculate the LDF by the following:

(i) Dividing each State's preliminary unreduced DSH allotment by their respective total Medicaid service expenditures for the applicable year.

(ii) Calculating for each State group the mean of all values determined in paragraph (e)(3)(i) of this section.

(iii) Dividing the value of paragraph (e)(3)(ii) of this section for the low-DSH State group by the value of paragraph (e)(3)(ii) for the non-low DSH state group.

(4) *LDF application.* CMS will determine the final aggregate DSH allotment reduction allocation for each State group through application of the LDF by the following:

(i) Multiplying the LDF by the aggregate DSH allotment reduction for the low DSH State group.

(ii) Utilizing the value of paragraph (e)(4)(i) of this section as the aggregate DSH allotment reduction allocated to the low DSH State group.

(iii) Subtracting the value of paragraph (e)(4)(ii) of this section from the value of paragraph (e)(2)(ii) of this section for the low DSH State group; and (iii) adding the value of paragraph (e)(4)(iii) of this section to the value of paragraph (e)(2)(ii) of this section for the non-low DSH State group.

(5) *Reduction factor allocation.* CMS will allocate the aggregate DSH allotment reduction amount to three core factors by multiply the aggregate DSH allotment reduction amount for each State group by the following:

(i) UPF—33 and ⅓ percent.

(ii) HMF—33 and ⅓ percent.

(iii) HUF—33 and ⅓ percent.

(6) *Uninsured percentage factor (UPF) calculation.* CMS will calculate the UPF by the following:

(i) Dividing the total State population by the uninsured in State for each State.

(ii) Determining the uninsured reduction allocation component for each State as a percentage by dividing each State's value of paragraph (e)(6)(i) of this section by the sum of the values of paragraph (e)(6)(i) of this section for the respective State group (the sum of the values of all States in the State group should total 100 percent).

(iii) Determine a weighting factor by dividing each State's unreduced DSH allotment by the sum of all preliminary unreduced DSH allotments for the respective State group.

(iv) Multiply the weighting factor calculated in paragraph (e)(6)(iii) of this section by the value of each State's uninsured reduction allocation component from paragraph (e)(6)(ii) of this section.

(v) Determine the UPF as a percentage by dividing the product of paragraph (e)(6)(iv) of this section for each State by the sum of the values of paragraph (e)(6)(iv) of this section for the respective State group (the sum of the values of all States in the State group should total 100 percent).

(7) *UPF application and reduction amount.* CMS will determine the UPF portion of the final aggregate DSH allotment reduction allocation for each State by multiplying the State's UPF by the aggregate DSH allotment reduction allocated to the UPF factor under paragraph (e)(5) of this section for the respective State group.

(8) *High volume of Medicaid inpatients factor (HMF) calculation.* CMS will calculate the HMF by determining a percentage for each State by dividing the State's total DSH payments made to non-high Medicaid volume hospitals by the total of such payments for the entire State group.

(9) *HMF application and reduction amount.* CMS will determine the HMF portion of the final aggregate DSH allotment reduction allocation for each State by multiplying the State's HMF by the aggregate DSH allotment reduction allocated to the HMF factor under paragraph (e)(5) of this section for the respective State group.

(10) *High level of uncompensated care factor (HUF) calculation.* CMS will calculate the HMF by determining a percentage for each State by dividing the State's total DSH payments made to non-High Uncompensated Care Level hospitals by the total of such payments for the entire State group.

(11) *HUF application and reduction amount.* CMS will determine the HUF portion of the final aggregate DSH allotment reduction allocation by multiplying each State's HUF by the aggregate DSH allotment reduction allocated to the HUF factor under paragraph (e)(5) of this section for the respective State group.

(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 for the specific fiscal year subject to reduction pursuant to an approval on or before July 31, 2009. CMS will calculate the BNF for qualifying states by the following:

(i) For States whose DSH allotment was included in the budget neutrality calculation for a coverage expansion that was approved under section 1115 as of July 31, 2009, (without regard to approved amendments since that date) determining the amount of the State's DSH allotment included in the budget neutrality calculation for coverage expansion for the specific fiscal year subject to reduction. This amount is not subject to reductions under the HMF and HUF calculations.

(ii) Determining the amount of the State's DSH allotment included in the budget neutrality calculation for non-coverage expansion purposes for the specific fiscal year subject to reduction.

(iii) Multiplying each qualifying State's value of paragraph (e)(10)(ii) of this section by the mean HMF reduction percentage for the respective State group.

(iv) Multiplying each qualifying State's value of paragraph (e)(10)(ii) of this section by the mean HUF reduction percentage for the respective State group.

(v) For each State, calculating the sum of the value of paragraphs (e)(10)(iii) and of (e)(10)(iv) of this section.

(13) *Section 1115 budget neutrality factor (BNF) application.* This factor will be applied in the State-specific DSH allotment reduction calculation.

(14) *State-specific DSH allotment reduction calculation.* CMS will calculate the state-specific DSH reduction by the following:

(i) Taking the sum of the value of paragraphs (e)(7), (e)(9), and (e)(11) of this section for each State.

(ii) For States qualifying under paragraph (e)(12) of this section, adding the value of paragraph (e)(12)(v) of this section.

(iii) Reducing the amount of paragraph (e)(14)(i) of this section for each State that does not qualify under paragraph (e)(12)(v) based on the proportion of each State's preliminary unreduced DSH allotment compared to the national total of preliminary unreduced DSH allotments so that the sum of paragraph (e)(14)(iii) of this section equals the sum of paragraph (e)(12)(v) of this section.

(f) *Annual DSH allotment reduction application.* For each fiscal year identified in paragraph (c) of this section, CMS will subtract the State-specific DSH allotment amount determined in paragraph (e)(14) of this section from that State's final unreduced DSH allotment. This amount is the State's final DSH allotment for the fiscal year.

■ 3. Section 447.299 is amended by adding paragraphs (c)(19), (c)(20) and (c)(21) to read as follows:

§ 447.299 Reporting requirements.

* * * * *

(c) * * *

(19) Medicaid provider number.

(20) Medicare provider number.

(21) *Total hospital cost.* The total annual costs incurred by each hospital for furnishing inpatient hospital and outpatient hospital services.

* * * * *

(Catalog of Federal Domestic Assistance Program No. 93.778, Medical Assistance Program)

Dated: April 26, 2013.

Marilyn Tavenner,

Acting Administrator, Centers for Medicare & Medicaid Services.

Approved: May 9, 2013.

Kathleen Sebelius,

Secretary, Department of Health and Human Services.

[FR Doc. 2013–11550 Filed 5–13–13; 11:15 am]

BILLING CODE 4120–01–P

NATIONAL FOUNDATION ON THE ARTS AND HUMANITIES

National Endowment for the Humanities

45 CFR Part 1172

RIN 3136–AA33

Nondiscrimination on the Basis of Age in Federally Assisted Programs or Activities

AGENCY: National Endowment for the Humanities, National Foundation on the Arts and Humanities.

ACTION: Proposed rule.

SUMMARY: The National Endowment for the Humanities (NEH) is issuing Age Discrimination Act of 1975 regulations at 45 CFR part 1172. These regulations implement provisions of the Age Discrimination Act of 1975 and the general, government-wide age discrimination regulations promulgated by the United States Department of Health and Human Services (HHS).

These regulations are designed to guide the actions of recipients of Federal financial assistance from NEH and incorporate the basic standards set forth in the general, government-wide regulations for determining what constitutes age discrimination. The regulations also discuss the responsibilities of NEH recipients and the investigations, conciliation, and enforcement procedures NEH has been using and will continue to use to ensure compliance with the Act.

DATES: Written comments must be postmarked and electronic comments must be submitted on or before July 15, 2013.

ADDRESSES: You may submit comments by any of the following methods: email to *gencounsel@neh.gov;* fax to 202–606–8600, please send your comments to the attention of Gina Raimond; or postal mail to Gina Raimond, Attorney Advisor, Office of the General Counsel, National Endowment for the Humanities, 1100 Pennsylvania Ave. NW., Room 529, Washington, DC 20506. To ensure proper handling, please reference ''Age Discrimination Act Regulations'' on your correspondence.

FOR FURTHER INFORMATION CONTACT: Gina Raimond, Office of the General Counsel, National Endowment for the Humanities, 202–606–8322 (voice) or 202–606–8282 (TDD).

SUPPLEMENTARY INFORMATION:

Background Information

The Age Discrimination Act of 1975, as amended, 29 U.S.C. 6101, *et seq.,* (the ''Act''), prohibits discrimination on the basis of age in programs or activities receiving Federal financial assistance. The Act, which applies to persons of all ages, also contains certain exceptions that permit, under limited circumstances, use of age distinctions or factors other than age that may have a disproportionate effect on the basis of age.

The Act required the former Department of Health, Education and Welfare (HEW) to issue general, government-wide regulations setting standards to be followed by all Federal agencies implementing the Act. These government-wide regulations, issued on June 12, 1979 and codified at 45 CFR part 90, require each agency to publish agency-specific regulations implementing the Act and to submit such final agency regulations to HEW (now HHS) before publication in the **Federal Register** (*see* 45 CFR part 90.31). The Act became effective on July 1, 1979—the effective date of HEW's final government-wide regulations—and NEH has enforced the provisions of the Act since that time. NEH first proposed agency-specific regulations implementing the Act on October 4, 1979 (44 FR 57130), which were closely based on the general, government-wide regulations. NEH's original proposed rule adopted many substantively identical sections and cross-referenced sections from the government-wide regulations, rather than repeating them in full. HHS reviewed and approved NEH's initial agency-specific regulations in 1985; however, NEH did not publish the final regulations.

Since such a significant amount of time has passed since NEH initially drafted the proposed rule, and because regulatory development guidelines have changed over the years, NEH determined that it would be best to begin the regulatory process anew by drafting new agency-specific age discrimination regulations. As a practical matter, however, the absence of agency-specific regulations has not affected NEH's enforcement of prohibitions against discrimination on the basis of age in programs or activities receiving financial assistance from NEH. Further, NEH has consistently fulfilled its obligation to report annually to Congress through HHS on its compliance and enforcement activities.

Overview of Proposed Rule

NEH has designed this proposed rule to fulfill the agency's statutory and regulatory obligations to issue a regulation implementing the Act that conforms to the government-wide regulations at 45 CFR part 90.