element Mission (Operational), in the ''description'' column; and

■ b. Revising the entry for Travel Purpose Identifier, next to the data element Conference-Other Than Training, in the ''description'' column.

The revisions read as follows:

Appendix C to Chapter 301—Standard Data Elements for Federal Travel [Traveler Identification]

Group name	Data elements	Description
* * * *	* * *	* * *
Travel Purpose Identifier	Mission (Operational)	Travel to a particular site in order to perform operational or managerial activities. Travel to attend a meeting to discuss general agency operations, review status reports, or discuss topics of general interest. *Examples:* Employee's day-to-day operational or managerial activities, as defined by the agency, to include, but not be limited to: Hearings, site visit, information meeting, inspections, audits, investigations, and examinations. Travel to a conference to serve as a speaker, panelist, or provide information in one's official capacity.
* * * *	* * *	* * *
	Conference—Other Than Training	Travel performed in connection with a prearranged meeting, retreat, convention, seminar, or symposium for consultation or exchange of information or discussion. Agencies have to distinguish between conference and training attendance and use the appropriate identifier (see Training below). *Examples:* To participate in a planned program as a host, planner, or others designated to oversee the conference or attendance with no formal role, or as an exhibitor.
* * * *	* * *	* * *

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PART 304–2—DEFINITIONS

■ 3. The authority citation for part 304–2 continues to read as follows:

Authority: 5 U.S.C. 5707; 31 U.S.C. 1353.

■ 4. Amend § 304–2.1 by—

■ a. Removing from the definition ''Meeting(s) or similar functions (meeting)'', introductory text, ''(*i.e.,* a function that is essential to an agency's mission)''.

■ b. Revising the second sentence of the definition ''Payment in kind''; and

■ c. Revise the last two sentences of the definitions ''Travel, subsistence, and related expenses (travel expenses)''.

The revisions read as follows:

§ 304–2.1 What definitions apply to this chapter?

* * * * *

Payment in kind * * * Payment in kind also includes waiver of any fees that a non-Federal source collects from meeting attendees (*e.g.,* registration fees), unless the employee attending the meeting or similar function is serving as a speaker, panelist, or presenter, and the fee is waived for all speakers, panelists, or presenters at the event.

* * * * *

Travel, subsistence, and related expenses (travel expenses) * * * The Foreign Affairs Manual is available for download from the internet at *FAM.state.gov.* The Joint Travel Regulations are available for download at *http://www.defensetravel.dod.mil/site/travelreg.cfm.*

PART 304–3—EMPLOYEE RESPONSIBILITY

■ 5. The authority citation for part 304–3 continues to read as follows:

Authority: 5 U.S.C. 5707; 31 U.S.C. 1353.

■ 6. Add § 304–3.10 to read as follows:

§ 304–3.10 If I am asked or assigned to participate as a speaker, panelist, or presenter at a meeting or similar function, and the organizing entity of the event waives the registration fee for all speakers, panelists, or presenters, is that a payment in kind?

No. A full or partial waiver of a registration fee by the organizing entity of the event is not a payment in kind when provided to speakers, panelists, or presenters.

Note to § 304–3.10: If registration fees are not waived for all speakers, panelists, or presenters, and instead are waived only for the Federal speakers, panelists, or presenters, then the waiver is considered to be a payment in kind, and must be reviewed under the procedures set forth in this chapter.

PART 304–6—PAYMENT GUIDELINES

■ 7. The authority citation for part 304–6 continues to read as follows:

Authority: 5 U.S.C. 5707; 31 U.S.C. 1353.

■ 8. Amend § 304–6.6 by revising paragraph (a) to read as follows:

§ 304–6.6 How do we determine the value of payments in kind that are to be reported on Standard Form (SF) 326?

* * * * *

(a) For conference, training, or similar fees waived or paid by a non-Federal source, you must report the amount charged to other participants, unless the employee attended the meeting or similar function as a speaker, panelist, or presenter, and the registration fee was waived for all speakers, panelists, or presenters by the organizing entity of the event.

* * * * *

[FR Doc. 2016–18556 Filed 8–12–16; 8:45 am]

BILLING CODE 6820–14–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 447

[CMS–2399–P]

RIN 0938–AS92

Medicaid Program; Disproportionate Share Hospital Payments—Treatment of Third Party Payers in Calculating Uncompensated Care Costs

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

ACTION: Proposed rule.

SUMMARY: This proposed rule addresses the hospital-specific limitation on Medicaid disproportionate share hospital (DSH) payments under section 1923(g)(1)(A) of the Social Security Act (Act), and the application of such limitation in the annual DSH audits required under section 1923(j) of the Act, by clarifying that the hospital-specific DSH limit is based only on uncompensated care costs. Specifically, this rule would make clearer in the text of the regulation an existing interpretation that uncompensated care costs include only those costs for Medicaid eligible individuals that remain after accounting for payments received by hospitals by or on behalf of Medicaid eligible individuals, including Medicare and other third party payments that compensate the hospitals for care furnished to such individuals. As a result, the hospital-specific limit calculation would reflect only the costs for Medicaid eligible individuals for which the hospital has not received payment from any source (other than state or local governmental payments for indigent patients).

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. September 14, 2016.

ADDRESSES: In commenting please refer to file code CMS–2399–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–2399–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–2399–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: Wendy Harrison, (410) 786–2075 and Rory Howe, (410) 786–4878.

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://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. Background

A. Legislative History

Title XIX of the Act authorizes the Secretary of the Department of Health and Human Services (the Secretary) to provide grants to states to help finance programs furnishing medical assistance (state Medicaid programs) to specified groups of eligible individuals in accordance with an approved state plan. ''Medical Assistance'' is defined at section 1905(a) of the Act as payment for part or all of the cost of a list of specified care for eligible individuals. Section 1902(a)(13)(A)(iv) of the Act requires that payment rates for hospitals take into account the situation of hospitals that serve a disproportionate share of low-income patients with special needs. Section 1923 of the Act contains more specific requirements related to payments for such disproportionate share hospitals (DSH) payments. These specific statutory requirements include aggregate state level limits, hospital-specific limits, qualification requirements, and auditing requirements.

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 it meets certain criteria. 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 fiscal year (FY) to the amount specified in an annual DSH allotment for each state. These allotments essentially establish a finite pool of available federal DSH funds that states use to pay the federal portion of payments to all qualifying hospitals in each state. As states often use most or all of their federal DSH allotment, in practice, if one hospital gets more DSH funding, other DSH-eligible hospitals in the state get less.

B. Hospital-Specific DSH Limit

Section 13621 of the Omnibus Budget Reconciliation Act of 1993 (OBRA 93), which was signed into law on August 10, 1993, added section 1923(g) of the Act, limiting Medicaid DSH payments during a year to a qualifying hospital to the amount of eligible uncompensated care costs during that same year. The Congress enacted the hospital-specific limit on DSH payments in response to reports that some hospitals received

DSH payment adjustments that exceeded ''the net costs, and in some instances the total costs, of operating the facilities.'' (H.R. Rep. No. 103–111, at 211–12 (1993), reprinted in 1993 U.S.C.C.A.N. 278, 538–39.) Such excess payments were inconsistent with the purpose of the Medicaid DSH payment, which is to ameliorate the real economic burden faced by hospitals that treat a disproportionate share of low-income patients and to ensure continued access to care for Medicaid patients. Accordingly, Congress imposed a hospital-specific limit that restricts Medicaid DSH payments to qualifying hospitals to the costs incurred by the hospital for providing inpatient and outpatient hospital services during the year to Medicaid eligible patients and individuals who have no health insurance or other source of third party coverage for the services provided during the year. Costs for providing services are ''as determined by the Secretary'' and are to be net of applicable payments received for those services.

The Congress revisited the DSH payment requirements in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Public Law 108–173, enacted on December 8, 2003. The MMA added section 1923(j) to the Act, which requires states to report specified information about their DSH payments, including independent, certified audits that, among other elements, are required to review compliance with the hospital-specific limits under section 1923(g)(1)(A) of the Act. Significantly, section 1923(j)(2)(B) of the Act provides a gloss on section 1923(g)(1)(A), by specifying that the audits must verify that ''Only the uncompensated care costs of providing inpatient hospital and outpatient hospital services to individuals described in paragraph (1)(A) of such subsection [1923(g) of the Act] are included in the calculation of the hospital-specific limits under such subsection.''

Until the establishment of an audit requirement, there was no standardization among the states as to how the hospital-specific limit was calculated. In the late 1990's and early 2000's the Government Accountability Office (GAO) and the U.S. Department of Health and Human Services Office of Inspector General (OIG) issued a series of reports focusing on the hospital-specific DSH limit. Among other findings, the GAO and OIG reports identified multiple instances where states included unallowable cost or did not account for costs net of applicable payments when determining the hospital-specific limits. These reviews and audits led to the enactment, as part of the MMA, of the audit requirements at section 1923(j) of the Act. Section 1923(j) of the Act not only required that we promulgate standardized audit methods and procedures, it also provided clarity on how the hospital-specific limit should be applied. The Congress explicitly addressed any ambiguity about whether the hospital-specific limit could include costs that have been compensated by payers other than the individual or the Medicaid program. Section 1923(j)(2)(C) of the Act specifically provides that only the uncompensated care costs of providing inpatient hospital and outpatient hospital services to individuals (described in section 1923(g)(1)(A of the Act) are included in the calculation of the hospital-specific limits under section 1923(g)(1)(A) of the Act. This provision makes clear that the Congress itself specified the hospital-specific limit at section 1923(g)(1) of the Act to include only uncompensated care costs.

As a result, it is clear that the Congress intended that FFP is not available for DSH payments that exceed a hospital's hospital-specific limit. The hospital-specific limit prevents hospitals from receiving DSH payments above the level of any net uncompensated cost incurred in the treatment of Medicaid eligible or uninsured individuals.

As indicated in a 2008 final rule describing the required DSH audit process, 73 FR 77904, 77926 (December 19, 2008), to be considered an inpatient or outpatient hospital service for purposes of Medicaid DSH, a service must meet the federal and state definitions of an inpatient hospital service or outpatient hospital service and must be included in the state's definition of an inpatient hospital service or outpatient hospital service under the approved state plan and reimbursed under the state plan as an inpatient hospital or outpatient hospital service. While a state may have some flexibility to define the scope of inpatient or outpatient hospital services covered by the state plan, a state must use consistent definitions. Hospitals may engage in any number of activities, or may furnish practitioner, nursing facility, or other services to patients that are not within the scope of inpatient hospital services or outpatient hospital services and are not paid as such. These services are not considered inpatient or outpatient hospital services for purposes of calculating the Medicaid hospital-specific DSH limit. In passing OBRA 93 and the hospital-specific DSH limit, the Congress contemplated that hospitals with ''large numbers of privately insured patients through which to offset their operating losses on the uninsured'' may not warrant Medicaid DSH payments (H. Rep. 103–111, p. 211).

C. The 2008 DSH Final Rule and Subsequent Policy Guidance

Section 1001 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) required annual 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.

In the August 26, 2005, **Federal Register** we published a proposed rule entitled, ''Medicaid Program; Disproportionate Share Hospital Payments'' (70 FR 50262) to implement the annual DSH audit and reporting requirements established or amended by the MMA. During the public comment period, one commenter requested clarification regarding the treatment of individuals dually eligible for Medicaid and Medicare for purposes of calculating the hospital-specific DSH limit. We responded to this comment in the final rule published in the **Federal Register** on December 19, 2008, entitled ''Medicaid Disproportionate Share Hospital Payments'' (73 FR 77904) (herein referred to as the 2008 DSH final rule). As section 1923(g) of the Act limits DSH payments on a hospital-specific basis to ''uncompensated costs,'' the response to the comment clarified that all costs and payments associated with individuals dually eligible for Medicare and Medicaid, including Medicare payments received by the hospital on behalf of the patients, must be included in the calculation of the hospital-specific DSH limit. The extent to which a hospital receives Medicare payments for services rendered to Medicaid eligible patients must be accounted for in determining uncompensated care costs for those services.

Following the publication of the 2008 DSH final rule, we received numerous questions from interested parties regarding the treatment of costs and payments associated with dual eligibles and Medicaid eligible individuals who also have a source of third party coverage (for example, coverage from a private insurance company) for purposes of calculating uncompensated care costs. We posted additional policy guidance titled ''*Additional Information on the DSH Reporting and Audit Requirements*'' on the Medicaid Web site at *https://www.medicaid.gov/medicaid-chip-program-information/by-topics/financing-and-reimbursement/*

downloads/part-1-additional-info-on-dsh-reporting-and-auditing.pdf providing that all costs and payments associated with dual eligibles and individuals with a source of third party coverage must be included in calculating the hospital-specific DSH limit, as section 1923(g) of the Act limits DSH payments to ''uncompensated'' care costs. This additional guidance was based upon the policy articulated in the 2008 final rule and sub-regulatory guidance issued to all state Medicaid directors on August 16, 2002.

In the August 16, 2002, letter to state Medicaid directors, we directed that when a state calculates the uninsured costs and the Medicaid shortfall for the OBRA 93 uncompensated care cost limits, it must reflect a hospital's costs of providing services to Medicaid patients and the uninsured, net of Medicaid payments (except DSH) made under the state plan and net of third party payments. Medicaid payments, include but are not limited to regular Medicaid fee-for-service rate payments, any supplemental or enhanced payments and Medicaid managed care organization payments. The guidance also stated that not recognizing these payments would overstate a hospital's amount of uninsured costs and Medicaid shortfall, thus inflating the OBRA 93 uncompensated care cost limits for that particular hospital. As state DSH payments are limited to an annual federal allotment, this policy is necessary to ensure that limited DSH resources are allocated to hospitals that have a net financial shortfall in serving Medicaid patients.

Prior to the 2008 final rule, some states and hospitals were excluding both costs and payments associated with Medicaid eligible individuals with third party coverage, including Medicare, when calculating hospital-specific DSH limits (or were including costs while not including payments). This practice led to the artificial inflation of uncompensated care costs and, correspondingly, of hospital-specific DSH limits and permitted some hospitals to be paid based on the same costs by two payers—once by Medicare or other third party payer and once by Medicaid. The clarification included in the final rule and associated implementation promotes fiscal integrity and equitable distribution of DSH payments among hospitals by preventing payment to DSH hospitals based on costs that are covered by Medicare or a private insurer. It also promotes program integrity by ensuring that hospitals receive Medicaid DSH payments only up to the actual uncompensated care costs incurred in providing inpatient and outpatient hospital services to Medicaid eligible individuals or individuals with no health insurance or other source of third party coverage.

Given the timing of the final rule and audit requirements, we recognized that there could have been a retroactive impact on some states and hospitals if the requirements had been imposed immediately. To ensure that states and hospitals did not experience any immediate adverse fiscal impact due to the publication of the DSH audit and reporting final rule and to foster development and refinement of auditing techniques, we included a transition period in the final rule. During this transition period, states were not required to repay FFP associated with Medicaid DSH overpayments identified through the annual DSH audits. The final rule allowed for a 3 year period between the close of the state plan rate year and when the final audit was due to us, which meant that audits for state plan rate year 2008 were not due to us until December 31, 2011. Recognizing that states would be auditing state plan rate years that closed prior to publication of the final rule, we stated in the final rule that there would be no financial implications until the audits for state plan rate year 2011 were due to us on December 31, 2014. This allowed states and hospitals to adjust to the audit requirements and make adjustments as necessary. This resulted in a transition period for the audits associated with state plan rate years 2005 through 2010.

The 2008 DSH final rule also reiterated our policy that costs and payments are treated on an aggregate, hospital-specific basis. For purposes of this hospital-specific limit calculation, any Medicaid payments, including but not limited to regular Medicaid fee-for-service rate payments, supplemental/enhanced Medicaid payments, and Medicaid managed care organization payments, made to a disproportionate share hospital for furnishing inpatient and outpatient hospital services to Medicaid eligible individuals, which are in excess of the Medicaid incurred costs for these services, are applied against the total uncompensated care costs of furnishing inpatient and outpatient hospital services to individuals with no source of third party coverage for such services.

In this policy verification, we explicitly acknowledge there will be instances where Medicaid payments will be greater than the cost of treating Medicaid eligible patients. However, to avoid overstating the hospital-specific limit, we nonetheless require that all Medicaid payments be included in the calculation, explaining that any ''excess'' payments will be applied against the uncompensated care costs that result from the uninsured calculation. The same principle applies to payments received from third party payers that exceed the cost of the service provided to a particular Medicaid eligible individual. All third party payments (including, but not limited to, payments by Medicare and private insurance) must be included in the calculation of uncompensated care costs for purposes of determining the hospital-specific DSH limit, regardless of what the Medicaid incurred cost is for treating the Medicaid eligible individual. For example, if a hospital treats two Medicaid eligible patients at a cost of $2,000 and receives a $500 payment from a third party for each individual and a $100 payment from Medicaid for each individual, the total uncompensated care cost to the hospital for is $800, regardless of whether the payments received for one patient exceeded the cost of providing the service to that individual.

Subsequent to both the 2008 DSH final rule and the interpretive issued guidance, multiple states, hospitals, and other stakeholders expressed concern regarding this policy and requested clarification. In addition to requests for clarification, some states have challenged this policy. We have disapproved one state plan amendment proposing to exclude the portion of a Medicare payment that exceeds the cost providing a service to a dual eligible and one state plan amendment proposing to exclude the portion of a third party commercial that exceeds the cost providing a service to a Medicaid eligible individual with private insurance coverage. Additionally, some hospitals and state governments have sued us regarding the treatment of third party payers in calculating uncompensated care costs.

In light of the statutory requirement limiting DSH payments on a hospital-specific basis to uncompensated care costs, it is inconsistent with the statute to assist hospitals with costs that have already been compensated by third party payments. This proposed rule is designed to reiterate the policy and make explicit within the terms of the regulation that all costs and payments associated with dual eligibles and individuals with a source of third party coverage must be included in calculating the hospital-specific DSH limit. This policy is necessary to ensure that only actual uncompensated care costs are included in the Medicaid hospital-specific DSH limit. And,

because state DSH payments are limited to an annual federal allotment, this policy is also necessary to ensure that limited DSH resources are allocated to hospitals that have a net financial shortfall in serving Medicaid patients.

In a simplified example, consider a state that has only two hospitals. The first hospital treated only patients who were either uninsured or eligible for Medicaid, and received no payments other than from Medicaid. The hospital-specific limit for this hospital would be equal to the hospital's total costs of treating its patients through inpatient hospital or outpatient hospital services minus the non-DSH Medicaid payments. The second hospital, on the other hand, treated only patients who were either uninsured or dually eligible for Medicaid and Medicare, and received no payments other than from Medicaid and Medicare. Under 1902(a)(13)(A)(iv) of the Act, the ''situation'' of the second hospital that receives comparatively generous payments from Medicare for the dual eligibles is relevantly different than the ''situation'' of the first hospital that has not received such payments. Our policy—that Medicare and other third party payments must be taken into account when determining a hospital's costs for the purpose of calculating Medicaid DSH payments—ensures that the DSH payment reflects the real economic burden of hospitals that treat a disproportionate share of low-income patients (*i.e.* the ''situation'' of the hospitals). Turning back to the example, the hospital-specific limit for the second hospital must take into account both the Medicaid and Medicare payments. If the hospital-specific limit did not take into account the Medicare payments, the second hospital would be able to receive DSH dollars in excess of its uncompensated care costs. As federal DSH funding is limited by the state-wide DSH allotment, the excess DSH payments to the second hospital may be at the expense of the first hospital, which could otherwise receive these DSH dollars.

II. Specific Proposed Regulatory Changes

A. Treatment of Payments Associated With Dual Eligibles and Medicaid Eligible Individuals With a Source of Third Party Coverage Under Section 1923(g) of the Act

We are proposing to clarify the hospital-specific limitation on Medicaid DSH payments under section 1923(g)(1)(A) of the Act and annual DSH audit requirements under section 1923(j) of the Act. Specifically, this rule proposes to modify the terms of the current regulation to make it explicit that ''costs'' for purposes of calculating hospital-specific DSH limits are costs net of third-party payments received.

We are proposing at § 447.299 to clarify the definition of ''Total cost of care for Medicaid IP/OP services'' to specify that the total annual costs of inpatient hospital and outpatient hospital (IP/OP) services must account for all third party payments, including, but not limited to payments by Medicare and private insurance.

We are aware of at least one court that has questioned whether it is a permissible interpretation of the statute to take third party payments into account when calculating the uncompensated care costs of treating Medicaid patients. The court reasoned that because Congress had expressly stated that costs must be net of Medicaid payments, it was unreasonable to interpret the statute as allowing other payments, not specifically mentioned, to be taken into account. At this time, we respectfully disagree. We believe that our interpretation—that all third party payments should be taken into account—better reflects the real economic burden of hospitals that treat a disproportionate share of low-income patients, and accordingly, better facilitates the Congressional directive of section 1923 of the Act in general and the hospital-specific limit in particular. Additionally, we believe that the statutory language indicating that costs are ''as determined by the Secretary'' gives us the discretion to take Medicare and other third party payments into account when determining a hospital's costs for the purpose of calculating Medicaid DSH payments. Nevertheless, in light of the court's opinion, we request comments on this issue.

III. Collection of Information Requirements

This document does not impose new information collection and recordkeeping requirements, though states will continue to be required to meet annual reporting requirements in 42 CFR 447.299. The burden for these requirements is currently approved under OMB #0938–0746 with an expiration date of March 31, 2017. Consequently, this proposed rule need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. Chapter 35).

IV. 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.

V. Regulatory Impact Statement

A. Statement of Need

This proposed regulation would ensure that only the uncompensated care costs for covered services provided to Medicaid eligible individuals are included in the calculation of the hospital-specific DSH limit, as required by section 1923(g) of the Act.

B. Overall Impact

We have examined the impacts 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 Social Security 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). Section 3(f) of Executive Order 12866 defines a ''significant regulatory action'' as an action that is likely to result in a rule: (1) (Having an annual effect on the economy of $100 million or more in any 1 year, or adversely and materially affecting a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or state, local or tribal governments or communities (also referred to as ''economically significant''); (2) creating a serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raising novel legal or policy issues arising out of legal mandates, the President's priorities, or

the principles set forth in the Executive Order.

A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year). This rule does not reach the economic threshold and thus is not considered a major rule.

The RFA requires agencies to analyze options for regulatory relief for small entities, and if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small government jurisdictions. The great majority of hospitals and most other health care providers and suppliers are small entities, either by being nonprofit organizations or by meeting the SBA definition of a small business (having revenues of less than $7.5 million to $38.5 million in any 1 year).

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.

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 2016, that is approximately $146 million. Since this rule would not mandate spending costs on state, local, or tribal governments in the aggregate, or by the private sector over the threshold of $146 million or more in any 1 year, the requirements of the UMRA are not applicable.

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 regulation does not impose any costs on state or local governments, the requirements of Executive Order 13132 are not applicable.

C. Anticipated Effects

1. Effects on State Medicaid Programs

Because this is not a change in policy, we do not anticipate that this proposed rule would have significant financial effects on state Medicaid programs. This rule would only make explicit within the terms of the regulation that ''costs'' for purposes of section 1923(g) of the Act are costs net of third-party payments.

2. Effects on Other Providers

Because this is not a change in policy, we do not anticipate that this proposed rule would have significant financial effects on other providers. This rule would only make explicit within the regulation that ''costs'' for purposes of section 1923(g) of the Act are costs net of amounts that have been paid by third parties and will ensure a more equitable distribution of Medicaid DSH payments within each state.

D. Alternatives Considered

We considered not proposing this rule. However, numerous states and other stakeholders have requested clarification regarding this requirement. Accordingly, we are proposing to make explicit within the terms of our regulation our existing policy that implements section (j) of the Act, in part.

Additionally, we considered issuing additional policy guidance through sub-regulatory means, such as a letter to all state Medicaid directors. However, we anticipate that modifying the regulatory text of 42 CFR part 447 is as clear and comprehensive as possible on this issue, avoiding any need for future clarification.

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 as follows:

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

■ 2. Section 447.299 is amended by revising paragraph (c)(10) to read as follows:

§ 447.299 Reporting requirements.

* * * * *

(c) * * *

(10) *Total Cost of Care for Medicaid IP/OP Services.* The total annual costs incurred by each hospital for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individuals. The total annual costs are determined on a hospital-specific basis, not a service-specific basis. For purposes of this section, costs—

(i) Are defined as costs net of third-party payments, including, but not limited to, payments by Medicare and private insurance.

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

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Dated: July 19, 2016.

Andrew M. Slavitt,

Acting Administrator, Centers for Medicare & Medicaid Services.

Dated: July 29, 2016.

Sylvia M. Burwell,

Secretary, Department of Health and Human Services.

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