on people of color, low-income populations, and/or indigenous peoples. While it is difficult to assess the environmental justice implications of this proposed action because the EPA cannot geographically identify or quantify the resulting source-specific emission reductions, the EPA believes that this proposed action is likely to either reduce or have no adverse impact on existing disproportionate and adverse effects on people of color, low-income populations and/or indigenous peoples. The basis for this decision is contained in section IX of this preamble.

K. Judicial Review

Section 307(b)(1) of the CAA governs judicial review of final actions by the EPA. This section provides, in part, that petitions for review must be filed in the Court of Appeals for the District of Columbia Circuit: (i) When the agency action consists of ''nationally applicable regulations promulgated, or final actions taken, by the Administrator,'' or (ii) when such action is locally or regionally applicable, if ''such action is based on a determination of nationwide scope or effect and if in taking such action the Administrator finds and publishes that such action is based on such a determination.'' For locally or regionally applicable final actions, the CAA reserves to the EPA complete discretion whether to invoke the exception in (ii).[68]

The EPA is proposing to issue SIP calls to eight states (applicable in 10 statewide and local jurisdictions) located in four of the ten EPA regions pursuant to a uniform process and analytical approach. The EPA is proposing to apply a nationally consistent policy regarding SSM provisions in SIPs in each of these eight states as a follow-up to EPA's larger 2015 SSM SIP Action, in which the Agency issued SIP calls pursuant to the same nationally consistent policy to 36 states (applicable in 45 statewide and local jurisdictions), for which petitions for review were all filed in the D.C. Circuit in 2015. The jurisdictions that would be affected by this action, if finalized, represent a wide geographic area and fall within six different judicial circuits.

If the Administrator takes final action on this proposal, then, in consideration of the effects of the action across the country, the EPA views this action to be ''nationally applicable'' within the meaning of CAA section 307(b)(1). In the alternative, to the extent a court finds this proposal, if finalized, to be locally or regionally applicable, the Administrator intends to exercise the complete discretion afforded to him under the CAA to make and publish a finding that this action is based on a determination of ''nationwide scope or effect'' within the meaning of CAA section 307(b)(1).[69]

XI. Statutory Authority

The statutory authority for this proposed action is provided in CAA section 101 *et seq.* (42 U.S.C. 7401 *et seq.*).

List of Subjects in 40 CFR Part 52

Environmental protection, Affirmative defense, Air pollution control, Carbon dioxide, Carbon dioxide equivalents, Carbon monoxide, Excess emissions, Greenhouse gases, Hydrofluorocarbons, Incorporation by reference, Intergovernmental relations, Lead, Methane, Nitrogen dioxide, Nitrous oxide, Ozone, Particulate matter, Perfluorocarbons, Reporting and recordkeeping requirements, Shutdown and malfunction, Startup, State implementation plan, Sulfur hexafluoride, Sulfur oxides, Volatile organic compounds.

Michael S. Regan,

Administrator.

[FR Doc. 2023–03575 Filed 2–23–23; 8:45 am]

BILLING CODE 6560–50–P

[68] In deciding whether to invoke the exception by making and publishing a finding that this action, if finalized, is based on a determination of nationwide scope or effect, the Administrator intends to take into account a number of policy considerations, including his judgment balancing the benefit of obtaining the D.C. Circuit's authoritative centralized review versus allowing development of the issue in other contexts and the best use of agency resources.

[69] In the report on the 1977 Amendments that revised CAA section 307(b)(1), Congress noted that the Administrator's determination that the ''nationwide scope or effect'' exception applies would be appropriate for any action that has a scope or effect beyond a single judicial circuit. See H.R. Rep. No. 95–294 at 323–24, reprinted in 1977 U.S.C.C.A.N. 1402–03.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 433, 447, 455, and 457

[CMS–2445–P]

RIN 0938–AV00

Medicaid Program; Disproportionate Share Hospital Third-Party Payer Rule

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

ACTION: Proposed rule.

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

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on April 25, 2023.

ADDRESSES: In commenting, please refer to file code CMS–2445–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

Comments, including mass comment submissions, must be submitted in one of the following three ways (please choose only one of the ways listed):

1. *Electronically.* You may submit electronic comments on this regulation to *https://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–2445–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–2445–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

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

FOR FURTHER INFORMATION CONTACT: Lia Adams, (410) 786–8258, Charlie Arnold, (404) 562–7425, Richard Cuno, (410) 786–1111, Stuart Goldstein, (410) 786–0694, Charles Hines, (410) 786–0252, and Mark Wong, (415) 744–3561, for Medicaid Disproportionate Share Hospital Payments and Overpayments. Jennifer Clark, (410) 786–2013, for Children's Health Insurance Program (CHIP).

SUPPLEMENTARY INFORMATION:

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 website as soon as possible after they have been received: *https://www.regulations.gov.* Follow the search instructions on that website to view public comments. CMS will not post on *Regulations.gov* public comments that make threats to individuals or institutions or suggest that the individual will take actions to harm the individual. CMS continues to encourage individuals not to submit duplicative comments. We will post acceptable comments from multiple unique commenters even if the content is identical or nearly identical to other comments.

I. Background

A. Overview

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

Section 1902(a)(13)(A)(iv) of the Act requires that States consider the situation of hospitals that serve a disproportionate share of low-income patients with special needs, in a manner consistent with section 1923 of Act, in determining payments. The purpose of this proposed rule is to update the regulatory requirements of the disproportionate share hospital (DSH) program in response to the Consolidated Appropriations Act, 2021 (herein, referred to as the CAA) (Pub. L. 116–260, December 27, 2020) and to further improve upon the program. More specifically, the proposed provisions seek to implement the DSH-related provisions of the CAA concerning the treatment of third-party payments for purposes of calculating Medicaid hospital-specific DSH limits. We note that the CAA also created new supplemental payment reporting requirements through the addition of section 1903(bb) of the Act; however, DSH payments were specifically excluded from these requirements, and we have issued guidance on those requirements.[1]

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

For the CAA-related provisions of this proposed rule, we propose an applicability date of October 1, 2021, to align with the effective date in the statute. This information is noted in each of the CAA-related provision sections. We propose that the remaining provisions, if finalized, would be effective 60 days after publication of the final rule.

B. Disproportionate Share Hospital (DSH) Payments

1. Background

States are statutorily required to make DSH payments to qualifying hospitals that serve patients who are uninsured and enrolled in the Medicaid program, as described in section 1923(d) of the Act. States generally have flexibility regarding the specific hospitals to which they make payments and how they determine the amount of those payments, within certain parameters. Section 1902(a)(13)(A)(iv) of the Act requires that States consider the situation of hospitals that serve a disproportionate number of low-income patients with special needs, in a manner consistent with section 1923 of the Act. DSH payments are not considered part of base payments or supplemental payments to providers, as they are made under distinct statutory authority. Section 1923 of the Act contains specific requirements related to DSH payments, including aggregate annual State-specific DSH allotments that limit Federal financial participation (FFP) for Statewide total DSH payments under section 1923(f) of the Act, and hospital-specific limits on DSH payments under section 1923(g) of the Act. Under the statutory hospital-specific limits, a hospital's DSH payments may not exceed the costs incurred by that hospital in furnishing inpatient and outpatient hospital services during the year to certain Medicaid beneficiaries and the uninsured, less payments received under title XIX (other than section 1923 of the Act) and payments by uninsured patients. In addition, section 1923(a)(2)(D) of the Act requires States to provide an annual report to the Secretary describing the DSH payment adjustments made to each DSH.

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

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

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

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

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

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

3. Annual DSH Audits and Overpayments

The ''Medicaid Program; Disproportionate Share Hospital Payments'' final rule published in the December 19, 2008 **Federal Register** (73 FR 77904) (and herein referred to as the 2008 DSH audit final rule) sets forth the data elements necessary to comply with the requirements of section 1923(j) of the Act related to auditing and reporting of DSH payments under State Medicaid programs. The regulations at 42 CFR 447.299(c) finalized in the 2008 DSH audit final rule outline 18 data elements States must submit to CMS, at the same time as the State submits the completed audit required under 42 CFR 455.304, in order to permit CMS verification of the appropriateness of such payments. One such data element is the total uncompensated care cost, which equals the total cost of care for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individuals and to individuals with no source of third-party coverage for the hospital services they receive, less the sum of other payment sources listed in § 447.299(c)(16). Despite the robust data, potential data gaps may exist as a result of an auditor identifying an area, or areas, in which documentation is missing or unavailable for certain costs or payments that are required to be included in the calculation of the total eligible uncompensated care costs.

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

In the past, the Office of Inspector General (OIG) and the Government Accountability Office (GAO) have raised concerns similar to ours regarding oversight of the Medicaid DSH program. The 2008 DSH audit final rule addressed concerns raised by the OIG [2] by implementing in regulations the independent certified audit requirements under section 1923(j) of the Act, by requiring States to include data elements as specified in § 447.299(c) with their annual audits. In 2012, the GAO published the report ''Medicaid: More Transparency of and Accountability for Supplemental Payments are Needed.'' [3] Although Medicaid DSH payments are not ''supplemental payments,'' as described previously, they are akin to supplemental payments, and thus, the GAO's report did not focus on supplemental payments exclusively. As part of the report, the GAO analyzed the 2010 DSH audits for 2007 DSH payments and found DSH payments that did not comply with the audit requirements specified in part 455, subpart D. For each of the required DSH audit elements, there were a number of hospitals for which the GAO could not determine compliance due to data reliability or documentation issues. For example, the GAO could not determine compliance with the requirement that uncompensated care costs are accurately calculated for 33.7 percent of hospitals analyzed by GAO. The report highlights that, although the independent certified audit requirements have allowed us to identify various compliance issues and quantify some provider overpayments, in some instances, findings remain unquantified.

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

Amounts in excess of the hospital-specific limit are regarded as overpayments to providers, under 42 CFR part 433, subpart F. Section 1903(d)(2)(C) of the Act provides that, when an overpayment by a State is discovered, the State has a 1-year period to recover or attempt to recover the overpayment before an adjustment is made to FFP to account for the overpayment. FFP is not available for DSH payments that are found in the independent certified audit to exceed the hospital-specific limit. Currently, regulations in § 433.316 provide for determining the date of discovery of an overpayment, which is necessary to determine the statutory 1-year period, but it does not specify how this relates to the independent certified DSH audits required under section 1923(j)(2) of the Act and 42 CFR part 455, subpart D.

Accordingly, the discovery of overpayments necessitates the return of the Federal share, or redistribution by the State of the overpaid amounts to other qualifying hospitals, in accordance with the State's approved Medicaid State plan. While the preamble to the 2008 DSH audit final rule generally addressed the return or redistribution of provider overpayments identified through DSH audits, it did not include specific procedural requirements for returning or redistributing overpayments. Therefore, we have identified this area as an opportunity to strengthen program oversight and integrity protections,

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

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

specifically with respect to the overpayment and redistribution reporting process and requirements for identifying the financial impact of audit findings. In this proposed rule, we propose requirements to enhance these areas.

4. DSH Health Reform Reduction Methodology

Section 2551 of the Affordable Care Act [4] (ACA) amended section 1923(f) of the Act to require aggregate reductions to State Medicaid DSH allotments annually from FY 2014 through FY 2020, to account for the then-anticipated decrease in uncompensated care as a result of expansions of coverage authorized by the ACA. The ACA specified in section 1923(f)(7)(B) of the Act certain factors CMS must consider in implementing these reductions, and left certain components of the methodology to the Secretary of Health and Human Services to define (as described later in this section). The methodology is referred to as the DSH Health Reform Methodology (DHRM). We published a final rule in October 2013 that delineated a methodology to implement the annual reductions only for FY 2014 and FY 2015 in order to accommodate data refinement and methodology improvement for later reduction years. However, Congress has since modified section 1923(f)(7) of the Act several times such that the reductions have never taken effect. On September 25, 2019, we published a final rule [5] (2019 final rule) delineating a revised methodology for the calculation of DSH allotment reductions, which at that time were scheduled to begin in 2020. Congress has since further delayed the start of these reductions until FY 2024. The CAA modified section 1923(f) of the Act such that the reductions occur beginning FY 2024 through FY 2027, in the amount of $8 billion each year.

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

- UPF—The statute requires that States with *lower* uninsurance rates receive *higher* percentage DSH reductions. Calculations performed under this factor utilize Census Bureau data that is subject to a 1-year lag.
- HMF—The statute requires that States that target DSH payments to hospitals with high Medicaid volume receive a *lower* percentage reduction in their DSH allotment. Calculations performed under this factor utilize DSH audit data that is on a 3-year lag.
- HUF—As required by statute, States that target DSH payments to hospitals with high levels of uncompensated care receive a *lower* percentage reduction in their DSH allotment. Calculations performed under this factor utilize DSH audit data that is on a 3-year lag.
- Low DSH State factor—Section 1923(f)(7)(B)(ii) of the Act requires that statutorily defined ''low DSH States'' receive a lower overall DSH reduction percentage than non-low DSH States. To accomplish this, low DSH States and non-low DSH States are separated into two cohorts before applying the reduction methodology.
- BNF—DSH allotment amounts diverted for coverage expansion under section 1115 demonstrations approved as of July 31, 2009, receive a limited protection from reduction.

5. Modernizing the Publication of Annual DSH and CHIP Allotments

Section 447.297 provides a process and timeline for us to publish preliminary and final annual DSH allotments and national expenditure targets in the **Federal Register**. The current requirements specify that we publish DSH preliminary allotments and national expenditure targets by October 1 of each Federal fiscal year (FFY), and publish the final allotments and national expenditure targets by April 1 of that FFY. We have found the current regulatory **Federal Register** publication process to be time consuming and administratively burdensome for us, and ultimately unnecessary in light of more timely notification practices already taking place.

Similarly, section 2104 of the Act provides appropriations for FY CHIP allotments for FYs 1998 through 2027. Regulations at 42 CFR 457.609 describe the process for calculating State CHIP allotments for a FY after FY 2008. Section 457.609(h) provides that CHIP allotments for a FY may be published as preliminary or final allotments in the **Federal Register** as determined by the Secretary. Similar to the current DSH allotment publication process, we have found the current FY CHIP allotment publication regulations administratively burdensome and less efficient than other means of notification. We propose to codify the process already taking place while eliminating inefficient and duplicative publication requirements.

II. Provisions of the Proposed Rule

A. Proposed Provisions

1. When Discovery of Overpayment Occurs and Its Significance (§ 433.316)

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

Accordingly, we are proposing to redesignate paragraphs (f) through (h) of § 433.316 as paragraphs (g) through (i), respectively, and to add a new proposed paragraph (f). In the new paragraph (f), we are proposing that, in the case of an

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

[5] 84 FR 50308.

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

2. DSH Health Reform Reduction Methodology (§ 447.294)

As discussed in section I.B.4 of this proposed rule, section 1923(f)(7)(B)(iii) of the Act requires that the methodology for calculating each State's Medicaid DSH allotment reduction, as first established by the ACA, consider the extent to which the DSH allotment for a State was included in the budget neutrality calculation for a coverage expansion approved under section 1115 (that is, a section 1115 demonstration to provide coverage to individuals not otherwise eligible for Medicaid) as of July 31, 2009. In the 2019 final rule, we finalized a policy to exclude from DSH allotment reductions the amount of DSH allotment States had approved as of July 31, 2009, under a coverage expansion section 1115 demonstration. Any DSH allotment amounts included in budget neutrality calculations for non-coverage expansion purposes (for example, where DSH allotment amounts included in budget neutrality calculations have been used to match State expenditures for approved delivery system reform initiatives) under approved 1115 demonstrations are still subject to reduction regardless of when they were approved. Further, the preamble to the 2019 final rule indicates that for any section 1115 demonstrations not approved as of July 31, 2009, these DSH allotment amounts included in budget neutrality calculations, whether for coverage expansion or otherwise, would also be subject to reduction. We note that all section 1115 demonstrations approved as of or before July 31, 2009, have expired and the protection does not apply to renewals or extensions of those 1115 demonstrations. Therefore, there no longer exist any amounts related to coverage expansion for us to exclude from future DSH allotment reductions scheduled to begin in FY 2024.

In the absence of DSH audit data relating to how States expend DSH allotment amounts diverted under section 1115 demonstrations, we propose to assign average HUF and HMF reduction percentages to these amounts.[6] We believe this approach is a reasonable method to determine reductions for the HUF and HMF factors, given the absence of relevant, hospital-specific DSH payment data for these payments. We considered using alternative percentages higher or lower than the average but settled on average percentages over concerns that these alternative percentages might provide an unintended benefit or penalty to these States for DSH diversions approved under a demonstration under section 1115 of the Act.

While the provisions of § 447.294(e)(12) are clear that we will assign average reductions to amounts associated with non-coverage expansion purposes in effect as of July 31, 2009, only the preamble to the 2019 final rule addresses the amounts diverted under a section 1115 demonstration approved after July 31, 2009. Additionally, the regulations are not specific regarding how these amounts are determined and accounted for in the DSH allotment reduction methodology. As such, we propose to update the regulations at § 447.294(e)(12) to clearly specify that amounts diverted under a section 1115 demonstration approved after July 31, 2009, are subject to average reductions under the HUF and HMF so that the regulation may better reflect the policy finalized in the 2019 final rule preamble.

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

Section 477.294(e)(12) introductory text and (e)(12)(i) currently align the amount of DSH allotment diverted under a section 1115 demonstration for a fiscal year with the fiscal year of the DSH allotment subject to reduction under section 1923(f)(7)(A)(ii) of the Act. We recognize that this non-alignment between the SPRY 2019 DSH audit data that we would use to determine the HUF and HMF, and the FY 2024 section 1115 demonstration budget neutrality calculation diversion amount that would be used under the current regulation, could result in inappropriate and illogical outcomes. For example, in a case where a State claimed all or almost all of its DSH allotment amount for DSH expenditures for the SPRY DSH audit utilized in the DHRM (here, SPRY 2019), but later diverted a large portion of its DSH allotment amount under a section 1115 demonstration during a year subject to DSH allotment reductions (here, FY 2024), the State could receive a reduction on an amount (including both DSH payments and DSH allotment diverted under a section 1115 demonstration) that is excess of the amount available under its current DSH allotment subject to reductions. Therefore, we believe our proposed approach is reasonable because in the absence of DSH audit data relating to how States expend DSH allotment amounts diverted under section 1115 demonstrations, CMS will assign average HUF and HMF reduction percentages to these diverted amounts. As such, it is appropriate that the amounts diverted under section 1115 demonstrations should align with the SPRY of the DSH audit used in the DHRM and that the amounts subject to reduction do not exceed what States

[6] 84 FR 50308 at 50328, wherein we discuss the policy to assign average amounts in the 2019 final rule.

could have expended, either through DSH payments or diverted DSH allotment amounts, during the associated SPRY. We considered leaving the current regulatory text unchanged. However, we believe it is important to update the current regulation in the interest of clarity and transparency and to avoid this potential outcome wherein a State might receive an inappropriately large reduction due to a misalignment of time periods for elements of the reduction methodology. Accordingly, we are proposing to revise § 477.294(e)(12) to remove language indicating that the BNF and budget neutrality calculations are applied to each State's amount of DSH allotment diverted under a section 1115 demonstration ''for the specific fiscal year subject to reduction.'' Further, we are proposing to amend § 477.294(e)(12)(ii) to specify that the budget neutrality calculations are performed on the amount of each State's DSH allotment diverted under an approved 1115 demonstration during the period that aligns with the associated SPRY DSH audit utilized in the DSH allotment reductions.

For States that divert their entire DSH allotment, and as such do not complete DSH audits, we are unable to use a DSH audit SPRY. Therefore, we are proposing to apply reductions under the HMF and HUF to the DSH allotment that the State would have had available during the demonstration year (DY) coinciding with the SPRY DSH audits utilized in the DHRM. We are also proposing to prorate the FFY allotment amount to determine this reduction in cases where the DY of the section 1115 demonstration crosses two FFYs. For example, as stated previously we would use SPRY 2019 DSH audit data for FFY 2024 DSH allotment reductions. However, if a State that diverts its entire DSH allotment has a DY that begins July 1, 2018, and ends June 30, 2019, we would have to determine the reduction amount associated with the diverted DSH allotment to reflect the amount of the FFY 2018 DSH allotment available from July 1, 2018, through September 30, 2018, and the amount of FFY 2019 DSH allotment available from October 1, 2018, through June 30, 2019. We do not believe it would be appropriate to calculate the reduction associated with the diverted DSH allotment using the full FFY 2019 DSH allotment because the diverted DSH funds would not have been available for the full DY ending June 30, 2019. For a State that diverts part of its DSH allotment, it would have a SPRY DSH audit already utilized in the DHRM. We would use the diverted DSH amount from the same SPRY, which may also involve prorating diverted DSH amounts from a DY, depending on whether the DY as specified in the section 1115 demonstration aligns with the SPRY. In previous rulemaking, we proposed and finalized a policy to utilize the most recent year available for all data sources and to align the SPRY of data sources whenever possible.[7] Providing this clarification in regulation through this rulemaking would accomplish this goal.

3. Hospital-Specific Disproportionate Share Hospital Payment Limit (§ 447.295)

Effective October 1, 2021, the amendments to section 1923(g) of the Act made by section 203 of the CAA change the methodology for calculating the Medicaid shortfall portion (Medicaid costs less Medicaid payments) of the hospital-specific DSH limit to only include costs and payments for hospital services furnished to beneficiaries for whom Medicaid is the primary payer. From June 2, 2017, to the effective date of the CAA, costs and payments for hospital services furnished to beneficiaries who were eligible for Medicaid, even when there was a third-party payer such as Medicare or other insurer, that pays primary to Medicaid for inpatient and outpatient hospital services, would all be included in the calculation of Medicaid shortfall portion of the hospital-specific DSH limits in accordance with the ''DSH Payments—Treatment of Third-Party Payers in Calculating Uncompensated Care Costs'' final rule in the April 3, 2017 **Federal Register**. Additionally, the CAA amended section 1923(g)(2) of the Act to provide an exception for certain hospitals that are in the 97th percentile or above of all hospitals with respect to the number of Medicare SSI days (that is, inpatient days made up of patients who, for such days, were entitled to Medicare Part A benefits and to SSI benefits) or percentage of Medicare SSI days to total inpatient days. In § 447.295(b), we are proposing to add the definition of ''97th percentile hospital'' to mean a hospital that is in at least the 97th percentile of all hospitals nationwide with respect to the hospital's number of Medicare SSI days or percentage of inpatient days that are Medicare SSI days, for the hospital's most recent cost reporting period. For hospitals that meet this criteria, section 1923(g)(2)(A) of the Act specifies that the hospital-specific DSH limit is the higher of the amount determined under the methodology as amended by section 203 of the CAA or the amount determined under the methodology in effect on January 1, 2020 (described previously), which we propose to implement in paragraph (d)(3) of the definition of ''Hospital-specific DSH limit calculation'' in § 447.295. As further discussed below, we also propose in the definition of 97th percentile hospital that CMS would identify the 97th percentile hospitals, for each Medicaid SPRY beginning on or after October 1, 2021, using Medicare cost reporting and claims data sources, as well as supplemental security income eligibility data provided by the Social Security Administration. CMS would publish lists identifying each 97th percentile hospital annually in advance of October 1 of each year and would revise a published list only to correct a mathematical or other similar technical error that is identified to CMS during the one-year period beginning on the date the lists are published.

For the October 1, 2021, effective date of the amendments to section 1923(g) of the Act made by section 203 of the CAA, we interpret these new requirements to be applicable for SPRYs ''beginning on or after'' the October 1, 2021, effective date. Previously, certain statutory references to ''fiscal year,'' such as in section 1923(g)(1) and (2) and (j)(1) of the Act, have also been interpreted as referring to each State's SPRY, instead of the FFY, when establishing requirements for the hospital-specific DSH limit (and audit requirements to ensure that payments comply with hospital-specific DSH limits). In the 2008 DSH audit final rule, CMS indicated that this interpretation was in ''recognition of varying fiscal periods between hospitals and States'' and that ''[t]he Medicaid [SPRY] is the period which each State has elected to use for purposes of DSH payments and other payments made in reference to annual limits.'' Further, we believe interpreting this provision to be applicable on an FFY basis would impose an excessive burden on States and hospitals. In particular, we believe such an interpretation would create a significant burden in situations when a hospital would qualify to meet the exception for 97th percentile hospitals for a portion of its SPRY, but not for the full SPRY, if qualification were determined on the basis of the FFY. This result would be likely to occur, given that the majority of States have SPRYs that do not align with the FFY. In these instances, States would need to prorate the uncompensated care costs, for affected hospitals, within a SPRY accordingly

[7] 82 FR 35155 at 35157; 84 FR 50308 at 50322.

since the methodology for calculating the Medicaid shortfall portion of the hospital-specific DSH limit may not be consistent for the entire SPRY if the hospital qualified as a 97th percentile hospital for only a portion of the SPRY. As such, we are proposing that section 203 of the CAA 2021, including the 97th percentile exception, be effective starting with each State's first SPRY beginning on or after October 1, 2021. For example, if a State's SPRY begins July 1, then the amendments made by section 203 of the CAA would be effective starting with the SPRY beginning July 1, 2022. Conversely, if a State's SPRY begins each year on October 1, then such amendments would be effective starting with the SPRY beginning October 1, 2021.

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

We are proposing to revise § 447.295(d) to reflect the statutory changes made by section 203 of the CAA to update the methodology for the calculation of the hospital-specific DSH limit to only include costs and payments for hospital services furnished to beneficiaries for whom Medicaid is the primary payer. In addition, we are proposing to revise § 447.295(d) to specify the methodology that hospitals meeting the exception for 97th percentile hospitals will utilize in the calculation of the hospital-specific DSH limit. Specifically, in § 447.295(d)(1), we propose to specify that for each State's Medicaid SPRYs beginning prior to October 1, 2021 and subject to proposed paragraph (d)(3), only costs incurred in providing inpatient hospital and outpatient hospital services to Medicaid individuals, and revenues received with respect to those services, and costs incurred in providing inpatient hospital and outpatient hospital services, and revenues received with respect to those services, for which a determination has been made in accordance with § 447.295(c) that the services were furnished to individuals who have no source of third-party coverage for the specific inpatient hospital or outpatient hospital service are included when calculating the costs and revenues for Medicaid individuals and individuals who have no health insurance or other source of third-party coverage for purposes of section 1923(g)(1) of the Act. In § 447.295(d)(2), we propose to specify that for each State's first Medicaid SPRY beginning on or after October 1, 2021, and thereafter, subject to proposed paragraph (d)(3), only costs incurred in providing inpatient hospital and outpatient hospital services to Medicaid individuals when Medicaid is the primary payer for such services, and revenues received with respect to those services, and costs incurred in providing inpatient hospital and outpatient hospital services, and revenues received with respect to those services, for which a determination has been made in accordance with § 447.295(c) that the services were furnished to individuals who have no source of third-party coverage for the specific inpatient hospital or outpatient hospital service are included when calculating the costs and revenues for Medicaid individuals and individuals who have no health insurance or other source of third-party coverage for purposes of section 1923(g)(1) of the Act. As noted above, we propose to implement the 97th percentile hospital exception in proposed § 447.295(d)(3), which would specify that, effective for each State's first Medicaid SPRY beginning on or after October 1, 2021, and thereafter, the hospital-specific DSH limit for a 97th percentile hospital defined in proposed paragraph (b) is the higher of the values from the calculations described in proposed paragraphs (d)(1) and (2).

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

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

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

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

We would determine each hospital's Medicare SSI days for discharges

occurring in the hospital's most recent cost reporting period, regardless of the length of that cost reporting period, using a data set that combines MEDPAR claims data and SSI eligibility data. We would utilize Medicare SSI days for discharges occurring in the cost reporting period, rather than Medicare SSI days occurring within the cost reporting period because the data source shows the Medicare SSI day count for each inpatient stay as a whole. This approach is consistent with how Medicare uses this data to develop the Medicare SSI days ratios for Medicare DSH purposes. Section 1886(d)(5)(F)(vi) of the Act, in describing the Medicare SSI percentage within the Medicare ''disproportionate patient percentage,'' refers to the ''number of such hospital's patient days for such period.'' Then the implementing regulations at 42 CFR 412.106 describe the Medicare SSI days used for Medicare DSH as patient days that ''are associated with discharges that occur during that period.'' This approach means if an inpatient stay begins in one cost reporting period but ends in the next cost reporting period, we would not count any of the inpatient stay's days toward the day count for the first cost reporting period, but instead count all of this inpatient stay's days toward the day count for the second cost reporting period. This approach would not favor the counting of days in one cost reporting period over others. On average, exclusion of days for inpatient stays that straddle between one cost reporting period and the hospital's next cost reporting period will be offset by any inclusion of days for inpatient stays that straddle between that one cost reporting period and the hospital's previous cost reporting period. Therefore, we can ensure we do not overinclude or underinclude Medicare SSI days for inpatient stays that straddle two cost-reporting periods.

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

We are proposing to utilize the Medicare SSI days and total inpatient days data to mathematically determine a threshold of acceptance to identify hospitals meeting the 97th percentile exception. The array includes either the values of Medicare SSI days or the percentage of inpatient days that are Medicare SSI days, for the universe of hospitals nationwide identified through this data process. For the Medicare SSI days, the 97th percentile threshold would be rounded to the nearest whole number, with x.5 or higher rounded up, and less than x.5 rounded down. Any hospital with Medicare SSI days for its most recent cost reporting period greater than or equal to the 97th percentile threshold would qualify as a 97th percentile hospital. For the percentage of inpatient days that are Medicare SSI days, all values would be rounded to the fourth decimal place (0.xxxx, alternatively stated as xx.xx percent), including each hospital's own percentage and the 97th percentile threshold. Values of 0.xxxx5 or higher would be rounded up, and less than 0.xxxx5 would be rounded down. Any hospital that has a percentage of total inpatient days that are Medicare SSI days from its most recent cost reporting period that is greater than or equal to the 97th percentile threshold would qualify as a 97th percentile hospital. The ranking will be on a national level, as the statutory language under section 203 of the CAA refers to ''97th percentile of all hospitals,'' which we believe is most consistent with a national, rather than a State-level ranking.

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

We are proposing to utilize both covered and non-covered Medicare Part A days when collecting data and calculating hospital percentiles. The statutory language in section 1923(g)(2)(B)(i) of the Act as modified by section 203 of the CAA specifically refers to patients who were entitled to benefits under part A of title XVIII. A patient's status as entitled to benefits under part A of title XVIII does not depend on whether payment for a particular inpatient day was available under Medicare Part A payment principles, and a qualifying Medicare beneficiary remains entitled to benefits under Part A even if Medicare payment is not available with respect to a particular inpatient day.[8] As such, we believe the calculations must include all Medicare Part A inpatient days, whether covered or non-covered, in the associated calculations. Further, this is consistent with CMS' use of covered and non-covered days in the Medicare SSI days ratio calculations for Medicare DSH payment purposes under section 1886(d)(5)(F)(vi)(I) of the Act, which describes a hospital's inpatient days for patients who were entitled to benefits under part A of title XVIII and were entitled to SSI benefits under title XVI of the Act.

Hospitals may provide acute inpatient hospital services, as well as other inpatient hospital services in distinct part units of the hospital. The distinct part units of a hospital that provide inpatient hospital services which are reported separately on the hospital's Medicare cost report are rehabilitation distinct part units and psychiatric distinct part units. We are proposing to include all inpatient days for inpatient hospital services reported on each hospital's Medicare cost report, including days furnished in distinct part units of the hospital that provide

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

inpatient hospital services, for purposes of determining a hospital's Medicare SSI days and total inpatient days. We note that Medicare pays for services furnished in these distinct part units under different payment systems from the acute care inpatient hospital services provided by the hospitals. However, for Medicaid purposes, the DSH uncompensated care costs of the hospital are inclusive of the costs of inpatient and outpatient hospital services furnished by the hospital, including those furnished in these distinct parts. Therefore, we believe the hospital's Medicare SSI days and total inpatient days should be inclusive of these distinct part unit days and not limited to acute inpatient hospital days.

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

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

Using the most recently available data as of March 31 in advance of October 1 each year would allow us a reasonable 6-month timeframe to pull data from each of these data sources, address any potential data issues, complete the necessary compiling and calculations, perform any data integrity checks, determine the 97th percentile and the hospitals meeting the threshold based either on the Medicare SSI days or the percentage of total inpatient days that are Medicare SSI days, and make the results available prior to October 1. States would then have the 97th percentile results applicable to the State's SPRY that begins between October 1 of that calendar year and September 30 of the following calendar year. The proposed March 31 date establishes a snapshot for a point in time each year that is reasonably close to October 1 of that same calendar year that we would use to determine what is the ''most recent'' data available for application to the upcoming SPRYs, while allowing us sufficient time to process the data and make the results available before the start of those SPRYs.

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

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

As noted earlier in this section, we are also proposing to include in the data set only hospitals that file a Medicare cost report. Because the Medicare cost report data are the source of total inpatient days, it is necessary for a hospital to file a Medicare cost report to calculate a hospital's Medicare SSI day as a percentage of total inpatient days. We cannot perform the calculations without this cost report information. Therefore, we propose to include only hospitals that file a Medicare cost report in the data set. Section 1923(g)(2)(B) of the Act recognizes the necessity of the Medicare cost report for the implementation of the 97th percentile exception by basing the qualification for the exception on the number or percentage of Medicare SSI days ''most recent cost reporting period.'' Therefore, we believe it is appropriate and consistent with the statutory requirements to include only these hospitals that have submitted Medicare cost reports in the data set for both 97th percentile exception lists. We do not anticipate this to be a problem, since any hospital serving Medicaid patients, but that does not file a Medicare cost report, would not qualify for the 97th percentile hospital exception. In accordance with § 413.24(f), Medicare-participating hospitals are required to file cost reports, which are generally due 5 months after the close of each cost reporting period. In accordance with Medicare Provider Reimbursement Manual, Part II, Section 110, hospitals with no Medicare utilization do not

need to file a cost report, and hospitals meeting low Medicare utilization thresholds may file a less than full cost report with limited information. Because a hospital would only qualify for the 97th percentile hospital exception with a relatively high volume of Medicare SSI days, a hospital with no or low Medicare utilization, and therefore, with no cost report or with a less than full cost report which would not have inpatient days data, would not qualify for the 97th percentile hospital exception.

Given that we are proposing to use snapshot cost report, claims, and eligibility data in advance of October 1 each year to produce nationwide lists applicable for each State's upcoming SPRY beginning on or after that October 1, we would not modify the 97th percentile qualification results based on a request by one or more individual hospitals (or by one or more States, with respect to one or more individual hospitals) to update or reconsider hospital cost report, claims, or eligibility data. The proposed snapshot approach recognizes that, at a given point in time, a hospital's most recent cost reporting period for which there is a cost report available in HCRIS, as well as the hospital's number of total inpatient days as reported in that most recent cost report and number of Medicare SSI days as determined from MEDPAR and SSI eligibility data sources, may be subject to future revision. However, to determine qualification for the 97th percentile hospital exception, we must select a point in time to capture snapshot data, and the resulting lists must provide reasonable certainty to hospitals and States nationwide regarding which hospitals qualify for the exception. This proposed rule would specify the snapshots (and their timing) that we would use in qualifying 97th percentile hospitals for each SPRY. It would not be prudent or reasonable to continuously revisit the 97th percentile hospital qualifications based on changing cost report, claims, or eligibility data, outside of those established snapshot parameters.

Nonetheless, we recognize there is a possibility of a mathematical or other similar technical error by CMS that could lead to a misidentification of the hospitals that qualify for the 97th percentile exception. In such a circumstance, we believe that it would be appropriate for us to correct our error, recognizing that this could result in some hospitals being determined eligible for the 97th percentile hospital exception that previously (erroneously) were not so listed, and other hospitals losing their previous (erroneous) designation as qualifying for the exception. At the same time, we must balance this consideration with the recognition that the published lists will be relied upon by States and hospitals for identifying which hospitals qualify for the exception, hospital-specific limits will be set accordingly, and DSH payments will be made; all interested parties (including hospitals, the States, and CMS) have an interest in finality for these payments after a reasonable time. Accordingly, we are proposing to allow 1 year from the posting of the 97th percentile hospital lists for States, hospitals, CMS, or other interested parties to identify any mathematical or other similar technical error, according to instructions that would appear on the published lists. Upon CMS verification that an error occurred that affected the hospitals appearing on a list of 97th percentile hospitals for a given year, we would determine and publish a revised list as soon as practicable. We believe 1 year is a reasonable timeline for identifying any mathematical or other similar technical error made by CMS, and would also allow a corrected qualifying list to be available in advance of the start of the independent DSH audit for the respective SPRY in most instances. For example, if this rule is finalized as proposed and we publish the qualifying lists in 2023 for application retroactively to a SPRY that begins October 1, 2021 (that is, SPRY 2022), we could post a corrected qualifying list, if necessary, sometime in 2024. Then, when the independent audit is performed for that SPRY in 2025, the final 97th percentile qualification lists would be available and not subject to any further changes. Accordingly, in paragraph (2) of the proposed definition of ''97th percentile hospital'' in § 447.295(b), we propose that CMS would publish lists identifying each 97th percentile hospital annually in advance of October 1 of each year. We propose that CMS would revise a published list only to correct a mathematical or other similar technical error that is identified to CMS during the one-year period beginning on the date the list is published.

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

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

We are proposing to eliminate the § 447.297(c) requirement to publish annual DSH allotments in the **Federal Register** and to provide that the Secretary will post preliminary and final national expenditure targets and State DSH allotments in the Medicaid Budget and Expenditure System/State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) and at *Medicaid.gov* (or similar successor system or website). Current regulations require us to publish the annual DSH allotments in the **Federal Register**. We have found this process to be time consuming and administratively burdensome for us, and are concerned that it makes providing the information to States and other interested parties less timely and accessible. Additionally, because we currently notify States directly regarding annual allotment amounts and make such information publicly available outside of the **Federal Register** on a routine basis, we find that it is duplicative and unnecessary to go through the process of publishing in the **Federal Register**. Therefore, by proposing to eliminate the § 447.297(c) requirement to publish annual DSH allotments in the **Federal Register** notice, we would be removing the administratively burdensome task, which would allow us to focus our efforts on providing the information in a timely and easily accessible manner through the MBES/CBES and at *Medicaid.gov* (or similar successor system or website).

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

5. Reporting Requirements (§ 447.299)

a. Calculating Medicaid Shortfall

We are proposing to revise § 447.299(c)(6), (7), (10), and (16) to reflect the statutory changes made by section 203 of the CAA to update the methodology for calculating the

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

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

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

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

Finally, we are proposing to revise § 447.299(c)(16), which specifies the calculation of uncompensated care costs, which include ''the total cost of care for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individuals'' and the uninsured, which are to be offset by ''Medicaid FFS rate payments, Medicaid managed care organization payments, supplemental/enhanced Medicaid payments, uninsured revenues, and section 1011 payments for inpatient and outpatient hospital services.'' Therefore, we are proposing to revise § 447.299(c)(16) to remove the reference to Medicaid eligible individuals and update the regulatory text to indicate that total annual uncompensated care cost equals the total cost of care for furnishing inpatient hospital and outpatient hospital services to Medicaid individuals, as determined in accordance with § 447.295(d), and to individuals with no source of third-party coverage for the hospital services they receive, less the sum of payments received on their behalf, should be included in this data element.

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

b. Reporting DSH Overpayments

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

Currently, audits may include a caveat indicating the auditors are unable to quantify the financial impact of an identified audit finding. We propose that, for purposes of this section, audit finding means an issue identified in the independent certified audit required under § 455.304 concerning the methodology for computing the hospital-specific DSH limit or the DSH payments made to the hospital, including compliance with the hospital-specific DSH limit as defined in § 447.299(c)(16). For example, an audit may identify that a hospital was unable to satisfactorily document the outpatient services it provided to Medicaid-eligible patients, resulting in the exclusion of associated costs and payments from the Medicaid shortfall calculation. Based on this lack of documentation, the audit may include a caveat noting the auditor's finding that the hospital's total uncompensated care cost may be misstated as a result of this exclusion, with unknown impact on the hospital-specific DSH limit. Given this lack of quantification of the financial impact of this finding, CMS and the State would be unable to determine whether an overpayment has resulted related to this

audit finding, and if so, the amount. We believe that requiring the quantification of such findings would limit the burden on States and CMS of performing follow-up reviews or audits. Specifically, conducting a secondary review or audit after the independent auditors have completed theirs would lengthen the review process, and therefore, delay the results of the audit. It would also require additional time, personnel, and resources by CMS, States, and hospitals to participate in a secondary review or audit, which would largely duplicate aspects of the audit already conducted by the independent auditor. If finalized, the new data element would help ensure appropriate recovery and redistribution, as applicable, of all DSH overpayments in excess of the hospital-specific limit. Adding this requirement to the submission will also ensure auditors provide the additional information at the time they are already reviewing the applicable data, reducing the labor burden as opposed to a later, secondary audit.

Auditors would be afforded the professional discretion and the flexibility to determine how to best quantify these amounts in the audit findings. For example, auditors would be able to use alternative source documentation, utilize a methodology to estimate the financial impact in terms of the dollar amount at risk, or provide an estimated range of financial impact if a determination of an exact dollar amount is not possible. However, we also understand that, due to the complexity of issues that may arise, the actual financial impact of an audit finding may not always be calculable. Therefore, we propose that, in the expectedly rare event that the actual financial impact cannot be calculated, a statement of the estimated financial impact for each audit finding identified in the independent certified audit that is not reflected in the other data elements identified in § 447.299(c) would be required. We propose that actual financial impact means the total amount associated with audit findings calculated using the documentation sources identified in § 455.304(c). Estimated financial impact means the total amount associated with audit findings calculated on the basis of the most reliable available information to quantify the amount of an audit finding in circumstances where complete and accurate information necessary to determine the actual financial impact is not available from the documentation sources identified in § 455.304(c). The estimated financial impact would use the most reliable available information (for example, related source documentation such as data from State systems, hospitals' audited financial statements, and Medicare cost reports) to quantify an audit finding as accurately as possible. We believe this additional data reporting element is necessary to better enable our oversight of the Medicaid DSH program to better ensure compliance with the hospital-specific DSH limit in section 1923(g) of the Act.

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

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

These proposals for the independent certified audit and DSH-related claims reporting would enhance Federal oversight of the Medicaid DSH program and improve the accuracy of DSH audit overpayments identified and collected through annual DSH audits. We invite comments on these proposals.

6. Definitions (§ 455.301)

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

We are soliciting comments related to this proposed change.

7. Condition for Federal Financial Participation (FFP) (§ 455.304)

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

Accordingly, we are proposing to revise § 455.304(d)(1), which specifies that auditors should verify that each qualifying hospital that receives DSH payments, associated with the provisions of services to ''Medicaid eligible individuals and individuals with no source of third-party coverage,'' is allowed to retain that payment. We are proposing this change because for most hospitals, for SPRYs beginning on or after October 1, 2021, the methodology by which these DSH payments were calculated and paid will be reflective of Medicaid costs and payments associated with Medicaid eligible individuals for whom Medicaid is the primary payer. Therefore, we are proposing to revise § 455.304(d)(1) to remove the reference to Medicaid eligible individuals and update the regulatory text to indicate that the DSH payments are associated with inpatient hospital and outpatient hospital services provided to Medicaid individuals as determined in accordance with § 447.295(d).

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

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

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

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

8. Process and Calculation of State Allotments for FYs After FY 2008 (§ 457.609)

We have not published CHIP allotments in the **Federal Register** since the FY 2013 CHIP allotments. Each year following FY 2013, States have been notified of their CHIP allotments through email notifications or MBES/CBES. We propose to remove from § 457.609(h), which references our discretionary option to publish in the **Federal Register** the national CHIP allotment amounts as determined on an annual basis for the FYs specified in statute. Instead, we are proposing to post CHIP allotments in the MBES/CBES and at *Medicaid.gov* (or similar successor systems or websites) annually. We believe that posting the CHIP allotment amounts at *Medicaid.gov* and in the MBES/CBES is an efficient way to increase transparency by making the information more easily accessible to interested parties and would be less administratively burdensome for us.

We are soliciting any comments related to these proposed changes.

III. Retroactive Application of the Rule

The amendments made by section Division CC, Title II, section 203 of the Consolidated Appropriations Act, 2021, require that the changes to the calculations of Medicaid hospital-specific DSH limits take effect on October 1, 2021, and apply to payment adjustments made under section 1923 of the Act during fiscal years beginning on or after that date. Accordingly, these provisions of this proposed rule, if finalized, will apply retroactively as set out in statute.

IV. Collection of Information Requirements

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

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

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

We are soliciting public comment on each of these issues for the following sections of this document that contain information collection requirements. Comments, if received, will be responded to within the subsequent final rule.

A. Wage Estimates

To derive average costs, we used data from the U.S. Bureau of Labor Statistics' (BLS) May 2021 National Occupational Employment and Wage Estimates for all salary estimates (*https://www.bls.gov/oes/current/oes_nat.htm*). In this regard, Table 1 presents BLS' mean hourly wage, our estimated cost of fringe benefits and overhead (calculated at 100 percent of salary), and our adjusted hourly wage.

TABLE 1—NATIONAL OCCUPATIONAL EMPLOYMENT AND WAGE ESTIMATES

Occupation title	Occupation code	Mean hourly wage ($/hr)	Fringe benefits and overhead ($/hr)	Adjusted hourly wage ($/hr)
Accountants and auditors	13–2011	40.37	40.37	80.74
Financial Specialist all other	13–2099	38.64	38.64	77.28
Managers all other	11–9199	62.36	62.36	124.72

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

B. Proposed Information Collection Requirements

The following regulatory sections of this rule contain proposed collection of information requirements (or ''ICRs'') that are subject to OMB review and approval under the authority of the PRA. Our analysis of the proposed requirements and burden follow.

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

1. ICRs Regarding DSH Reporting Requirements (§ 447.299)

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

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

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

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

We believe the additional burden associated with the new data element would be 2 hours given that auditors are already engaged in a focused review of available documentation to quantify the aggregate amounts that comprise each of the existing data elements required under § 447.299(c). We also estimate that the additional 2 hours would consist of 1 hour at $77.28/hr. for a financial specialist to add the additional data to the report and 1 hour at $124.72/hr for management and professional staff to review the additional data in the report. In aggregate we estimate an annual burden of 102 hours (50 States × 2 hr/response × 1 response/year) at a cost of $10,100 (50 States × [(1 hr × $124.72/hr) + (1 hr × $77.28/hr)]).

If the auditor is unable to determine the actual financial impact amount of an audit finding, the auditor would be required to provide a statement of the estimated financial impact for each audit finding identified in the independent certified audit. For the purposes of this burden estimate, we will assume every State may have some quantifiable findings and some unquantifiable findings. As such, we anticipate that a State auditor would have to spend an additional 1 hour at $80.74/hr quantifying the financial impact of DSH findings that are classified as unknown. The estimated annual burden would be 50 hours (50 States × 1 hr) at a cost of $4,037 (50 hr × $80.74/hr).

C. Summary of Annual Burden Estimates for Proposed Requirements

Table 2 summarizes the burden for the proposed provisions.

TABLE 2—PROPOSED ANNUAL RECORDKEEPING AND REPORTING REQUIREMENTS

Regulation section(s) under title 42 of the CFR	OMB control No. (CMS ID No.)	Respondents	Responses (per state)	Total responses	Time per response (hours)	Total annual time (hours)	Labor costs ($/hr)	Total cost ($)
§ 447.299 DSH audit	0938–0746 (CMS–R–266)	50	1	51	2	102	varies	10,100
		50	1	51	1	51	80.74	4,037
Total	.....	50	2	102	varies	153	varies	14,137

The audit requirement proposal represents the only information collection provision of this rule. As such, we estimate there would be a total annual burden of 153 hours at a cost of $14,420 and an average per State burden of 3 hours (153 hr/51 States) and $282.75 ($14,420/51 States).

D. Submission of PRA-Related Comments

We have submitted a copy of this proposed rule to OMB for its review of the rule's ICRs. The requirements would not be effective until they have been approved by OMB.

To obtain copies of the supporting statement and any related forms for the proposed collections discussed in this rule, please visit the CMS website at *www.cms.hhs.gov/PaperworkReductionActof1995,* or call the Reports Clearance Office at 410–786–1326.

We invite public comments on this potential ICR. If you wish to comment, please submit your comments electronically as specified in the **DATES** and **ADDRESSES** section of this proposed rule and identify the rule (CMS–2445–P), the ICR's CFR citation, and the OMB control number.

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 would 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 would respond to the comments in the preamble to that document.

V. Regulatory Impact Analysis

A. Statement of Need

This proposed rule would codify in Federal regulations the statutory requirements of Division CC, Title II, section 203 of the CAA, which relate to Medicaid shortfall and third-party payments. These changes are necessary to align with Federal statute, and to provide States and hospitals an understanding of how qualifying hospitals' DSH payments may be impacted by the legislation. These changes are necessary in order to reflect the statutory changes to section 1923(g) of the Act to update the methodology for calculating the Medicaid shortfall portion of the hospital-specific DSH limit to only include costs and payments for hospital services furnished to beneficiaries for whom Medicaid is the primary payer, and to codify the exception for certain hospitals that are in the 97th percentile or above of all hospitals with respect to the number of Medicare SSI days or percentage of Medicare SSI days to total inpatient days.

Since we were required to engage in rulemaking in order to codify the statutory changes made under the CAA, we are also taking the opportunity to update certain DSH regulations in order to provide additional clarity and efficiency. The proposed changes to the BNF and associated calculations performed under the DHRM will provide better clarity for States that divert all or a portion of their DSH allotment under an approved section 1115 demonstration.

Additional Medicaid DSH payments and requirements are addressed in this proposed rule. We propose to add additional specificity to the reporting requirements of the annual DSH audit conducted by an independent auditor to enhance Federal oversight of the Medicaid DSH program. Additionally, we seek to improve the accurate identification of and collection efforts related to overpayments identified through the annual DSH independent certified audits by specifying the date of discovery and standards for return of FFP or redistribution of DSH payments made to providers in excess of the hospital-specific limit. The proposed rule also seeks to alleviate the administrative burden of publishing the annual DSH and CHIP allotments in the **Federal Register**, of which we also notify States directly by providing notification through other, more practical means.

B. Overall Impact

We have examined the impacts of this proposed 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). 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 beneficiaries 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.

Based on our estimates using a ''no action'' baseline, OMB's Office of Information and Regulatory Affairs has determined that this rulemaking is ''economically significant,'' as discussed in more detail in this section.

C. Detailed Economic Analysis

Some amendments made by the CAA required us to propose regulatory updates, but there are statutory changes that are effective regardless of our actions. Typically, under OMB Circular

A–4, our analysis for instances such as this would utilize a ''pre-statute'' baseline. However, we are unable to assess the impact of the statutory changes in a meaningful way. Therefore, for the purposes of assessing the incremental economic impact, we determined the most appropriate analysis is to compare the effects of this rulemaking against a ''no action'' baseline in accordance with OMB Circular A–4. This baseline incorporates the statutory changes made by the CAA that do not require rulemaking to be in effect, such as the change to the definition of Medicaid shortfall. This will be the focus of our analysis. Similarly, for the non-CAA-required or related DSH provisions in this proposed rule, our analytical baseline is a direct comparison between the proposed provisions and not proposing the rule.

Because the impact of our rule depends on downstream impacts of changes created in statute unaffected by this rulemaking, such as the change to only include Medicaid costs and payments in the hospital-specific DSH limit when Medicaid is the primary payer, calculating financial cost and transfer impacts specific to this rulemaking presents challenges which we will discuss further in those sections.

1. Benefits

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

2. Costs

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

To estimate the overall burden of adding this requirement for the calculation of the hospital-specific DSH limit for hospitals meeting the exception for 97th percentile hospitals, we considered the number of annual independent certified audits received by CMS in addition to the limited number of hospitals that will qualify under this exception. In order for States to assess which hospitals meet the exception, we estimate that it would take approximately 2 hours, consisting of: 1 hour at $77.28/hr for a financial specialist to prepare the aforementioned spreadsheet report, and 1 hour at $124.72/hr for management and professional staff to review the report. In the aggregate, we estimate an ongoing annual burden of 102 hours (51 States × 2 hr/response × 1 response/year) at a cost of $10,302 ((51 States × [(1 hr $124.72/hr) + (1 hr × $77.28/hr)] or $202 per State ($10,302/51 States). Additionally, we anticipate that a State auditor would have to spend an additional hour verifying the hospital-specific DSH limits for hospitals meeting the exception for 97th percentile hospitals. The estimated annual burden would be 1 hour per State (51 States × 1 hour) 51 hours × $80.74/hr for auditors to complete the audit at a cost of $4,118 per year (51 States × 1 hour × $80.74 per hour). The total cost of this provision of the proposed rule would be $14,420 ($10,302 + $4,118) and 153 hours, or $282.74 and 3 hours per State.

The additional DSH audit data reporting element creates a burden of 153 hours at a cost of $14,420, with an average of 3 hours ($282.74 hr/51 States) at a cost of $282.74 per State Medicaid agency per year ($14,420/51 States).

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

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

3. Transfers

Although the policies discussed in this proposed rule would affect the calculation of the hospital-specific DSH limit established at section 1923(g) of the Act and some providers may see a decrease in their historic hospital-specific DSH limits, these effects are a direct result of statutory changes rather

than the proposals in this rule. In addition, some providers may see an increase in their historic hospital-specific DSH limits, again as a result of the changes made by statute. Further, lower hospital-specific DSH limits for some hospitals may result in States choosing to distribute higher DSH payments to hospitals that historically had not been paid at higher levels. We note that this rule would not affect the considerable flexibility afforded States in setting DSH State plan payment methodologies to the extent that these methodologies are consistent with section 1923(c) of the Act and all other applicable statutes and regulations. Therefore, we cannot predict whether and how States would exercise their flexibility in setting DSH payments to account for changes in historic hospital-specific DSH limits and how this would affect individual providers or specific groups of providers. We invite comments from State agencies and hospitals providing information or data for the calculation of these estimates.

4. Regulatory Review Cost Estimation

If regulations impose administrative costs on private entities, such as the time needed to read and interpret this proposed rule, we estimate the cost associated with regulatory review. Due to the uncertainty involved with accurately quantifying the number of entities that will review the rule, we assume that States, Medicaid DSH hospitals, and independent auditors will be likely reviewers of this proposed rule. We acknowledge that this assumption may understate or overstate the costs of reviewing this rule. It is possible that not all Medicaid DSH hospitals will choose to review individually, or that State agencies will have multiple people in different roles review. Nevertheless, we thought the entities directly or indirectly impacted by this rule served as the best basis. As such, we will assume half of the approximately 2,700 Medicaid DSH hospitals will review the rule, in addition to at least one person from each of the 51 State agencies impacted by this rule, and at least one person from the independent DSH auditor for each of the 51 States, resulting in 1,502 total entities. We welcome any comments on the approach in estimating the number of entities which will review this proposed rule.

Although this rule has a number of provisions, they more or less all relate to DSH, and we assume entities with DSH equities will review the entire rule. Using the wage information from the BLS, *https://www.bls.gov/oes/current/oes119111.htm,* for medical and health service managers (Code 11–9111), we estimate that the cost of reviewing this rule is $115.22 per hour, including overhead and fringe benefits. We estimate that it would take approximately 2 hours for the staff to review this proposed rule. For each entity that reviews the rule, the estimated cost is $230.44 (2 hours × $115.22). Therefore, we estimate that the total one-time cost of reviewing this regulation is $346,121 ($230.44 × 1,502).

D. Alternatives Considered

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

1. Not Proposing the Rule

Before undertaking this rulemaking, we examined if States and hospitals could have the necessary information regarding the changes made by the CAA through alternative sub-regulatory guidance. However, upon review we concluded that, due to the changes to regulatory language necessitated by the legislation, rulemaking was necessary. Apart from that, we considered not including the additional DSH proposals and maintaining the status quo. However, based on the generally favorable response these proposals received in prior rulemaking that was not finalized, we determined it the best use of our time and resources to include them once the need for rulemaking was identified.

2. The 97th Percentile Hospital Qualification Data Source

We considered using a readily existing data source to determine the application of this exception. In State Medicaid Director letter #21–006, we indicated that we assessed the ability to utilize the Medicare SSI days and ratio information for use in the Medicare DSH adjustment calculation for IPPS hospitals. However, we determined that this data source is not appropriate because the Medicare SSI ratio is determined using total Medicare Part A days in the denominator, while section 1923(g)(2)(B) of the Act specifies that a hospital must be at least in the 97th percentile of all hospitals with respect to its percentage of total inpatient days made up of patients who are both entitled to Medicare Part A and entitled to SSI benefits. In addition, the Medicare SSI days and ratio information made available by CMS for the Medicare DSH adjustment calculations does not include all types of hospitals that receive Medicaid DSH payments, including critical access hospitals and inpatient psychiatric facilities. Finally, the Medicare SSI days and ratio data made available by CMS for the Medicare DSH adjustment calculations are calculated based on the FFY, while the 97th percentile determination under section 1923(g)(2)(B) of the Act is based on the hospitals' most recent cost reporting periods. As such, we determined that it is necessary for CMS to develop an appropriate source of data that both featured a broader, although not exhaustive, universe of hospitals and aligned with statutory definition for the exception as set forth in section 1923(g)(2)(B) of the Act. The data we are using for the 97th percentile determination is inclusive of all hospital types; however, an individual hospital would be excluded if it does not have a Medicare cost report in the most recent cost reporting period that meets our selection parameters as discussed in this proposed rule.

We considered that the October 1, 2021 statutory effective date of section 203 of the CAA would apply to the FFY beginning October 1, 2021. However, we believe that this application does not align with how, for purposes of the DSH program, FY has been interpreted to refer to the applicable to the SPRY in prior rulemaking. Further, we believe an FFY application would be burdensome on States and hospitals. For example, if a State has a SPRY that does not align with the FFY and a hospital qualifies for the 97th percentile hospital exception for one FFY but not the next, the State would potentially need to prorate the total uncompensated care costs within a SPRY to account for this scenario. This process would need to be performed for each hospital and in each SPRY when this scenario occurs.

We considered proposing that the exception for 97th percentile hospitals be applied on a Statewide rather than a national level. However, the statutory language under section 203 of the CAA refers to ''97th percentile of all hospitals,'' which we believe is most consistent with a national, rather than a State-level ranking.

We considered determining a hospital's qualification for the 97th percentile exception for each SPRY on a retroactive basis in order to better align the time periods associated with the cost report and SSI eligibility data with the SPRY subject to qualification. However, this application would require CMS to retroactively rank and qualify hospitals for a SPRY based on actual Medicare SSI days and ratios for services furnished during that SPRY. This application would create uncertainty for States and hospitals in making DSH payments and calculating hospital-specific DSH limits, given the time delay inherent in a retroactive application of the exception. This

approach also likely would require more financial transactions to return payments to hospitals in excess of the hospital-specific DSH limits to the State, which would then be required to return associated FFP to CMS or redistribute the returned overpayment amounts to other qualifying hospitals. Similar increases in financial transactions would occur in a State that paid below its hospital-specific DSH limits. These additional transactions would be administratively burdensome, and potentially financially burdensome in particular for the hospitals required to return additional amounts.

With respect to rounding, for performing the calculations necessary for the determination of hospitals qualifying for the 97th percentile exception, we considered various mathematical approaches. We considered an approach of rounding down the 97th percentile threshold while rounding up each hospital's own value in order to be more generous to potentially allow additional hospitals qualify for the exception. However, we believe this would create an inconsistent rounding policy and could be viewed as arbitrary. Therefore, we proposed what we believe to be a more consistent mathematical approach.

We considered utilizing only most recent audited or settled cost reporting period, but have determined that the use of as-submitted cost reporting period would result in more current and more consistent reporting periods across hospitals. Further, we considered using the total patient day count from only the ''as submitted'' cost report from the most recent cost reporting period even if there happens to be a later status (such as amended or settled or reopened) on that same cost report. However, we have determined that even though the total patient days seldom change between the as-submitted, amended, settled, and reopened cost reports, we should still use the latest available data. As such, we have proposed to use the total inpatient days from the cost report with the most updated cost report status, for the most recent cost reporting period, available on the day that the data are pulled, in determining the hospitals that meet the 97th percentile threshold.

We are proposing to use Medicare SSI days associated with discharges occurring within each hospital's most recent cost reporting period. We did consider identifying Medicare SSI days for the inpatient days occurring within each hospital's most recent cost reporting period instead. However, the claims data that we are using identifies the number of Medicare SSI days for each inpatient hospital stay as a whole. We do not believe it is practical or necessary to attempt to allocate Medicare SSI days between two cost reporting periods for those inpatient hospital stays that straddle between two cost reporting periods, when using days associated with discharges occurring within a cost reporting also results in an equitable counting of days and is consistent with how Medicare identifies Medicare SSI days for Medicare DSH purposes, as explained earlier in this rule.

We considered proposing to utilize only covered Medicare Part A days when collecting data and calculating hospital percentiles. Using only covered Medicare Part A days would have meant in determining the Medicare SSI days for each inpatient stay, we would have to limit the Medicare SSI days to no more than the covered Medicare Part A days for that stay. The statutory language set forth in law by section 203 of the CAA specifically describes the Medicare SSI days as relating to patients who were entitled to benefits under part A of title XVIII and were entitled to SSI benefits under title XVI. As such, we believe the calculations must include all Medicare Part A inpatient days, whether covered or non-covered, in the associated calculations. As discussed previously, the use of covered and non-covered days is also consistent with Medicare's DSH adjustment calculation for IPPS hospitals.

We considered not including the distinct part unit days reported on each hospital's Medicare cost report where the hospital has rehabilitation distinct part units and psychiatric distinct part units, in addition to the hospital's acute inpatient days. However, for Medicaid purposes, the DSH uncompensated care costs of the hospital would be inclusive of the costs of these rehabilitation and psychiatric distinct part units that provide inpatient hospital services; therefore, the hospital's Medicare SSI days and total inpatient days should be inclusive of these distinct part unit days in our calculations of hospitals that meet the 97th percentile threshold.

In determining when we can begin to collect and assemble the necessary data prior to the beginning of each upcoming SPRY that begins on or after October 1 each year, we are proposing to use HCRIS, MEDPAR, and SSI eligibility data as they exist as of March 31, in advance of October 1 of that same calendar year. We considered using a date closer to October 1, such as June 30, as the point in time to pull the ''most recent'' data available for application to the upcoming SPRYs. However, we selected March 31 to ensure there is sufficient time to gather the data, work through any potential data issues, perform the necessary calculations, and make the 97th percentile results available in advance of October 1. We also considered using a date in the preceding calendar year for the HCRIS snapshot while using a date in the current calendar year for the MEDPAR and SSI eligibility data snapshot. This alternative would allow greater assurance that for all the most recent cost reporting periods as of that HCRIS snapshot date, the claims data for services furnished in those identified cost reporting periods from a later MEDPAR and SSI eligibility snapshot date would include a longer claims run out period. However, we are not proposing this approach because we would no longer be utilizing ''the most recent cost reporting period'' for which there is a cost report available in HCRIS at the time we are performing this data extract and 97th percentile determination each year, as required by the amendments made by section 203 of the CAA.

Given the delay in developing a data set to implement section 203 of the CAA, we have proposed to determine the annual 97th percentile qualification using data available as it would have been available at the time it would have otherwise been collected and assembled prior to the SPRY to which it would apply, for SPRYs beginning during FFY 2022 and FFY 2023. We considered utilizing the most recently available cost report data available following the finalization of this rule in order to produce the source of data to qualify 97th percentile hospitals for both the current and past periods affected by section 203 of the CAA. However, we believe that the approach would result in some hospitals that would have otherwise qualified to meet the exception based on CMS' proposed data set timelines to not qualify if this more recent data are utilized. This could disqualify and penalize hospitals, that would have met the exception at that time, for a reason that was beyond their control. Conversely, some hospitals could qualify for the exception for SPRYs 2022 and 2023 based on the more recent data but would not have qualified using CMS' proposed data timelines. We believe it is more equitable to use the proposed data timeline consistently for all SPRYs beginning on or after October 1, 2021, regardless of the delay in the implementation. We have capability within the data source systems to retroactively extract such data as they existed at those particular points in time

(that is, March 31, 2021 for application to SPRYs beginning during FFY 2022 and March 31, 2022, for application to SPRYs beginning during FFY 2023).

We considered proposing a process in order include information for hospitals that do not have Medicare cost reports in the data set used to determine which hospitals meet the exception for 97th percentile hospitals. However, without a cost report CMS would not have the total inpatient day count readily available to compute the Medicare SSI day ratio. Even if we were to consider an alternative mechanism outside of the existing Medicare cost report data to collect total inpatient days data from those hospitals without Medicare cost reports in HCRIS, there would not be a way to define what the most recent cost reporting period would be for those hospitals that would be consistent with how we are defining it as proposed for hospitals that do have a cost report, which is based on what is the most recent cost reporting period available in HCRIS at a given point in time in advance of October 1 each year. Given that the plain language of section 203 of the CAA points to the days for ''the most recent cost reporting period,'' and we would not be able to associate these hospitals' nominal Medicare Part A days found in MEDPAR with a cost report, we believe it is reasonable to exclude hospitals with no cost report from the data set.

For hospitals with cost reports that are for periods less than 1 year, we considered annualizing the number of days for ranking purposes for qualification of the 97th percentile exception. However, hospitals with a short cost reporting period would still have an opportunity to qualify to meet the exception on the basis of the percentage of their Medicare SSI days to total inpatient days. Also, annualizing hospitals with a short cost reporting period could push a hospital with 12-month cost reporting period, that would have otherwise qualified, out of the ranking to qualify for the 97th percentile exception, based on what is in effect hypothetical data from another hospital's partial-year cost reporting period that would be extrapolated to a full year. Furthermore, for hospitals with cost reports that are for periods of greater than 1 year, we also considered annualizing the number of days to 12 months. However, doing that would again mean we are not using the number of days from the most recent cost reporting period as they are, and in this case potentially adversely affecting that hospital's own qualification for the 97th percentile exception by reducing its number of days hypothetically. Consistent with the treatment of hospitals with cost reports that are for periods less than 1 year, we are proposing to use the data as they are and not annualize for hospitals with cost reports that are for period greater than 1 year.

CMS considered various alternatives for making the determination regarding how far back the time period of a hospital's cost report could relate to in order to be included in the data set for the calculation of hospitals that meet the 97th percentile threshold exception. While we proposed not including any cost report ending earlier than September 30, 3 years prior to the March 31 snapshot date for compiling the data set, we considered a shorter cutoff, such as excluding any cost report ending earlier than September 30, 2 years prior to the March 31 snapshot date. However, we were concerned that establishing too short of a cutoff could exclude a material number of hospitals due to either delays in hospitals filing cost reports or delays in the transmitting and processing of cost report files into HCRIS. Conversely, we considered a longer cutoff than 3 years, but we were concerned this could create too much variability in the cost reporting periods and would also capture in the data set hospitals that are currently inactive or terminated. To control the uniformity in the cost reporting periods we are using, we also considered using only cost reports that begins or ends within a set FFY, but we would have to have selected a sufficiently old FFY in order to have a reasonably complete universe of hospitals due to time lags in cost reports showing up in HCRIS; in that case, for some hospitals those cost reports would no longer be for the most recent cost reporting period for which the hospital has a cost report in HCRIS. We believe our proposed cutoff is equitable in ensuring there is general consistency in the cost reporting periods used, conforms with the use of ''most recent cost reporting period,'' and is practical for implementation purposes.

3. Audit Requirement To Quantify Financial Impact of Audit Findings

We considered proposing to require auditors to clarify the impact of audit findings and caveats within the existing data element report by incorporating finding amounts into existing data elements (for example, Total Medicaid Uncompensated Care). However, this option may not enable auditors to effectively capture financial impacts of specific issues and such findings might not be readily transparent to States, CMS, and hospitals, as the quantified impacts of potential errors would be folded into figures that utilize verified data. Therefore, we opted to include this as an additional, discrete data element on the DSH report to ensure our ability to assess a quantified impact or the extent to which there is an issue that cannot be quantified.

4. Clarifying the Discovery Date for DSH Overpayments and Redistribution Requirements

We considered proposing to use the date that the auditor submits the independent certified audit to the State as the date of discovery for DSH overpayments identified through the independent certified audit, but ultimately decided to consider the date that a State submits the independent certified audit to CMS as the discovery date. The earlier date would start the clock for State repayment of FFP without regard to possible work that may need to occur between States and auditors to finalize the audit and associated reporting prior to submission to CMS.

5. Technical Changes To Publishing DSH and CHIP Allotments

We considered continuing the requirement and option to publish the DSH and CHIP allotments, respectively, in the **Federal Register**. However, we believe this is unnecessary as States are already informed regarding their annual DSH and CHIP allotments prior to the publication of the **Federal Register** notice that we now provide. In addition, we did not receive negative feedback via public comment when this change was proposed in prior rulemaking.

E. Accounting Statement and Table

As required by OMB Circular A–4 (available at *https://obamawhitehouse.archives.gov/omb/circulars_a004_a-4/*), we have prepared an accounting statement in Table 3 showing the classification of the costs associated with the provisions of this proposed rule.

TABLE 3—ACCOUNTING STATEMENT—CLASSIFICATION OF ESTIMATED COSTS

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

F. Regulatory Flexibility Act (RFA)

The RFA requires agencies to analyze options for regulatory relief of small entities, if a rule has a significant impact on a substantial number of small entities. The great majority of hospitals and most other health care providers and suppliers are small entities, either by being nonprofit organizations or by meeting the SBA definition of a small business (having revenues of less than $8.0 million to $41.5 million in any 1 year). Individuals and States are not included in the definition of a small entity. As its measure of significant economic impact on a substantial number of small entities, HHS uses a change in revenue of more than 3 to 5 percent. We do not believe that this threshold will be reached by the provisions in this proposed rule.

This rule establishes requirements that are solely the responsibility of State Medicaid agencies, which are not small entities. Therefore, the Secretary certifies this proposed rule would not, if promulgated, 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 and has fewer than 100 beds. This rule will not have a significant impact on the operations of a substantial number of small rural hospitals.

G. Unfunded Mandates Reform Act (UMRA)

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2022, that threshold is approximately $165 million. This rule does not contain mandates that will impose spending costs on State, local, or tribal governments in the aggregate, or by the private sector, in excess of the threshold.

H. Federalism

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

I. Conclusion

If the policies in this proposed rule are finalized, it will enable CMS to implement statutory changes, strengthen financial oversight, clarify existing financial management policies, and reduce unnecessary administrative burden.

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

Chiquita Brooks-LaSure, Administrator of the Centers for Medicare & Medicaid Services, approved this document on February 7, 2023.

List of Subjects

42 CFR Part 433

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

42 CFR Part 447

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

42 CFR Part 455

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

42 CFR Part 457

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

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

PART 433—STATE FISCAL ADMINISTRATION

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

Authority: 42 U.S.C. 1302.

■ 2. Amend § 433.316 by—
■ a. Redesignating paragraphs (f) through (h) as paragraphs (g) through (i), respectively; and
■ b. Adding a new paragraph (f).

The addition reads as follows:

§ 433.316 When discovery of overpayment occurs and its significance.

* * * * *

(f) *Overpayments identified through the disproportionate share hospital*

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

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

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

* * * * *

PART 447—PAYMENTS FOR SERVICES

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

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

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

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

* * * * *

(e) * * *

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

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

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

* * * * *

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

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

* * * * *

(b) * * *

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

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

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

* * * * *

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

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

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

§ 447.297 [Amended]

■ 6. Amend § 447.297 by—

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

■ b. In paragraph (c)—

■ i. Removing the phrase ''publish in the **Federal Register**'' and adding in its place the phrase ''post in the Medicaid Budget and Expenditure System/State Children's Health Insurance Program Budget and Expenditure System and at *Medicaid.gov* (or similar successor system or website)''; and

■ ii. Removing the phrase ''publish final State DSH allotments by April 1 of each Federal fiscal year,'' and adding in its place the phrase ''post final State DSH

allotments as soon as practicable for each Federal fiscal year,'';

■ c. In paragraph (d)(1), removing the phrase ''by April 1 of each Federal fiscal year'' and adding in its place the phrase ''as soon as practicable for each Federal fiscal year'' and by removing the phrase ''prior to the April 1 publication date'' and adding in its place the phrase ''prior to the posting date''; and

■ d. Removing paragraph (e).

■ 7. Amend § 447.299 by—

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

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

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

The revisions and additions read as follows:

§ 447.299 Reporting requirements.

* * * * *

(c) * * *

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

(7) *IP/OP Medicaid managed care organization payments.* The total annual amount paid to the hospital by Medicaid managed care organizations for inpatient hospital and outpatient hospital services furnished to Medicaid individuals, as determined pursuant to § 447.295(d).

* * * * *

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

* * * * *

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

* * * * *

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

* * * * *

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

* * * * *

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

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

PART 455—PROGRAM INTEGRITY: MEDICAID

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

Authority: 42 U.S.C. 1302.

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

§ 455.301 Definitions.

* * * * *

Independent certified audit means an audit that is conducted by an auditor that operates independently from the Medicaid agency or subject hospitals and is eligible to perform the disproportionate share hospital (DSH) audit. Certification means that the independent auditor engaged by the State reviews the criteria of the Federal audit regulation and completes the verification, calculations and report under the professional rules and

generally accepted standards of audit practice. This certification includes a review of the State's audit protocol to ensure that the Federal regulation is satisfied, an opinion for each verification detailed in the regulation, a determination of whether or not the State made DSH payments that exceeded any hospital's hospital-specific DSH limit in the Medicaid State plan rate year under audit, and a quantification of the financial impact of each audit finding on a hospital-specific basis. The certification also identifies any data issues or other caveats or deficiencies that the auditor identified as impacting the results of the audit.

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

§ 455.304 Condition for Federal financial participation (FFP).

* * * * *

(d) * * *

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

* * * * *

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

(4) *Verification 4.* For purposes of this hospital-specific limit calculation, any Medicaid payments (including regular Medicaid fee-for-service rate payments, supplemental/enhanced Medicaid payments, and Medicaid managed care organization payments) made to a disproportionate share hospital for furnishing inpatient hospital and outpatient hospital services to Medicaid individuals as determined pursuant to § 447.295(d) of this chapter, which are in excess of the Medicaid incurred costs of such services, are applied against the uncompensated care costs of furnishing inpatient hospital and outpatient hospital services to individuals with no source of third-party coverage for such services.

* * * * *

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

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PART 457—ALLOTMENTS AND GRANTS TO STATES

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

Authority: 42 U.S.C. 1302.

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

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

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

Dated: February 16, 2023.

Xavier Becerra,

Secretary, Department of Health and Human Services.

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