

DEPARTMENT OF HEALTH AND HUMAN SERVICES**42 CFR Part 7**

[Docket No. CDC–2013–0013]

RIN 0920–AA52

Distribution of Reference Biological Standards and Biological Preparations

AGENCY: Centers for Disease Control and Prevention (HHS/CDC), Department of Health and Human Services (HHS).

ACTION: Confirmation of effective date of direct final rule.

SUMMARY: The Centers for Disease Control and Prevention (CDC) within the Department of Health and Human Services (HHS) is publishing this document to confirm the effective date of the Direct Final Rule (DFR), published on July 22, 2013 (78 FR 43817).

DATES: The Direct Final Rule published at 78 FR 43817, July 22, 2013, will become effective on September 20, 2013.

FOR FURTHER INFORMATION CONTACT: For questions concerning this document: Dr. Carolyn M. Black, M.D., Division of Scientific Resources, Centers for Disease Control and Prevention, 1600 Clifton Road NE., Mailstop C–17, Atlanta, Georgia 30333; telephone 404–639–3466.

SUPPLEMENTARY INFORMATION: On July 22, 2013, HHS/CDC published a Direct Final Rule (DFR) amending 42 CFR part 7 to update the agency name, address, and contact information for that part (78 FR 43817). In that document, HHS/CDC indicated that if we did not receive any significant adverse comments on the direct final rule by August 21, 2013, we would publish a document in the **Federal Register** confirming the effective date of the direct final rule within 30 days after the end of the comment period. HHS/CDC did not receive significant adverse comment to the DFR. Therefore, consistent with the Direct Final Rule, the updated agency name and address and contact information for 42 CFR part 7 will become effective on September 20, 2013 (78 FR 43817).

Dated: September 11, 2013.

Kathleen Sebelius,
Secretary.

[FR Doc. 2013–22685 Filed 9–17–13; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES**Centers for Medicare & Medicaid Services****42 CFR Part 447**

[CMS–2367–F]

RIN 0938–AR31

Medicaid Program; State Disproportionate Share Hospital Allotment Reductions

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

ACTION: Final rule.

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

DATES: Effective Date: These regulations are effective on November 18, 2013.

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

SUPPLEMENTARY INFORMATION:**I. Executive Summary***A. Purpose*

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

B. Summary of the Major Provisions

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

C. Costs and Benefits

Taking these five factors into account for each state, the DHRM will generate a state-specific DSH allotment reduction amount for FY 2014 and FY 2015. The total of all DSH allotment reduction amounts will equal the aggregate annual

reduction amounts identified in the statute for FY 2014 and FY 2015. To determine the effective annual DSH allotment for each state, the state-specific annual DSH allotment reduction amount will be applied to the unreduced DSH allotment amount for its respective state.

II. Background*A. Introduction*

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

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

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

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

- Impose a smaller percentage reduction on low DSH states.
- Impose larger percentage reductions on states that have the lowest percentages of uninsured individuals during the most recent year for which such data are available.
- Impose larger percentage reductions on states that do not target their DSH payments on hospitals with high volumes of Medicaid inpatients.
- Impose larger percentage reductions on states that do not target their DSH payments on hospitals with high levels of uncompensated care.
- Take into account the extent to which the DSH allotment for a state was included in the budget neutrality calculation for a coverage expansion approved under section 1115 as of July 31, 2009.

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

B. Legislative History and Overview

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

To qualify as a DSH under section 1923(b) of the Act, a hospital must meet two minimum qualifying criteria in section 1923(d) of the Act. The first criterion is that the hospital has at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to Medicaid individuals. This criterion does not apply to hospitals in which the inpatients are predominantly individuals under 18 years of age or hospitals that do not offer nonemergency obstetric services to the general public as of December 22, 1987. The second criterion is that the hospital has a Medicaid inpatient utilization rate (MIUR) of at least 1 percent.

Under section 1923(b) of the Act, a hospital meeting the minimum

qualifying criteria in section 1923(d) of the Act is deemed as a DSH if the hospital's MIUR is at least one standard deviation above the mean MIUR in the state, or if the hospital's low-income utilization rate exceeds 25 percent. States have the option to define disproportionate share hospitals under the state plan using alternative qualifying criteria as long as the qualifying methodology comports with the deeming requirements of section 1923(b) of the Act. Subject to certain federal payment limits, states are afforded flexibility in setting DSH state plan payment methodologies to the extent that these methodologies are consistent with section 1923(c) of the Act. Section 1923(f) of the Act limits federal financial participation (FFP) for total statewide DSH payments made to eligible hospitals in each federal FY to the amount specified in an annual DSH allotment for each state. Although there have been some special rules for calculating DSH allotments for particular years or sets of years, section 1923(f)(3) of the Act establishes a general rule that state DSH allotments are calculated on an annual basis in an amount equal to the DSH allotment for the preceding FY increased by the percentage change in the consumer price index for all urban consumers for the previous FY. The annual allotment, after the consumer price index increase, is limited to the greater of the DSH allotment for the previous year or 12 percent of the total amount of Medicaid expenditures under the state plan during the FY. Allotment amounts were originally established in the Medicaid Voluntary Contribution and Provider Specific Tax Amendments of 1991 (Pub. L. 102–234 enacted on December 12, 1991) based on each state's historical DSH spending.

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

The statute requires annual aggregate reductions in federal DSH funding from FY 2014 through FY 2020. The aggregate annual reduction amounts are as follows:

- \$500 million for FY 2014.
- \$600 million for FY 2015.
- \$600 million for FY 2016.
- \$1.8 billion for FY 2017.
- \$5 billion for FY 2018.
- \$5.6 billion for FY 2019.

- \$4 billion for FY 2020.

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

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

The statute provides significant federal financial support for states to extend coverage to low-income adults under section 1902(a)(10)(A)(i)(VIII) of the Act. For a state that implements the new adult coverage group, the federal government will cover 100 percent of the cost of coverage for newly eligible individuals from 2014 through 2016 and no less than 90 percent thereafter. Hospitals will also receive full Medicaid reimbursement for many previously uninsured patients. So on balance, we believe both hospitals and states stand to benefit greatly from expanding Medicaid. In addition, new premium tax credits and cost sharing reductions will be available to low-income individual in all states.

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

Because states that implement the new coverage group would likely have reductions in the rates of uninsurance, the reduction in DSH funding may be greater for such states compared to states that do not implement the new coverage group. Consequently, hospitals in states implementing the new coverage group that serve Medicaid patients may experience a deeper reduction in DSH payments than they would if all states were to implement the new coverage group.

Currently, we do not have sufficient information on the relative impacts that would result from state decisions to implement the new coverage group, and thus, we proposed a DHRM only for the first 2 years during which the DSH funding reductions are in effect. We

intend to continue evaluating potential implications for accounting for coverage expansion in the DHRM. Accordingly, we proposed to establish a DHRM that would be in effect for FY 2014 and FY 2015 and we did not include a method to account for coverage expansion decisions in Medicaid for FY 2014 and FY 2015.

D. DHRM Data Sources

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

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

To date, we have received rich, comprehensive audit and reporting data

from each state that makes Medicaid DSH payments. To facilitate the provision of high quality data, we provided explicit parameters in the 2008 DSH final rule and associated policy guidance for calculating and reporting data elements. The 2008 DSH final rule included a transition period in which states and auditors could develop and refine audit and reporting techniques. This transition period covered data reported relating to state plan rate years 2005 through 2010. We recognize that the DSH audit and reporting data during this transition period may vary in its quality and accuracy from state to state and have considered utilizing alternative uncompensated cost data and Medicaid utilization data from sources such as the Medicare Form CMS-2552. The DSH audit and reporting data, however, remains the only comprehensive reported data available that is consistent with Medicaid program requirements. States are already required to report this data by the last day of the federal fiscal year ending 3 years from the Medicaid state plan rate year under audit as required by the 2008 DSH final rule. However, state submitted audit and reporting data is subject to detailed CMS review and may require significant resources to ensure that it is compiled and prepared for use in the proposed DHRM. This means that the data used for the methodology may not be the most recently submitted data, but instead the most recent data available for use in this context. We have been actively engaged in reviewing state audits and reports to ensure quality and accuracy. Consistent with ongoing efforts to ensure that the reported data is of the highest quality possible as we move through the transition period, we intend to issue additional detailed guidance to states by the end of calendar year (CY) 2013 that would be applicable to audits and reports due by the end of CY 2014.

As required by the statute, the DHRM must impose the larger percentage DSH allotment reductions on the states that have the lowest percentages of uninsured individuals. Although other sources of this information could be considered for this purpose, the statute explicitly refers to the use of data from the Census Bureau for determining the percentage of uninsured for each state. We identified and considered two Census Bureau data sources for this purpose, the American Community Survey (ACS); and the Annual Social and Economic Supplement to the Current Population Survey (CPS). In consultation with the Census Bureau,

we proposed to use the data from the ACS for the following reasons. First, the ACS is the largest household survey in the United States; in that regard, the annual sample size for the ACS is over 30 times larger than that for the CPS—about 3 million for the ACS versus 100 thousand for the CPS. The ACS is conducted continuously each month throughout the year, with the sample for each month being roughly 1/12th of the annual total, while the CPS is conducted in the first 4 months following the end of the survey year. Finally, although the definition of uninsured and insured status is the same for the ACS and the CPS, the CPS considers the respondents as uninsured if they are uninsured at any time during the year whereas the ACS whether the respondent has coverage at the time of the interview, which are conducted at various times throughout the year. For these reasons, and with the recommendation of the Census Bureau, we determined that the ACS is the appropriate source for establishing the percentage of uninsured for each state for purpose of the proposed DHRM.

In addition to Census Bureau data, we considered using various alternative data with different population parameters and/or different definitions of uninsured individuals, but ultimately decided to utilize the ACS as the source for establishing the percentage of uninsured for each state. We are also considering adjusting the definition of the uninsured for reductions applicable for FY 2016 and beyond reductions through separate rulemaking.

III. Provisions of the Proposed Regulations and Analysis of and Responses to Public Comments

In response to the publication of the State Disproportionate Share Hospital Allotment Reductions proposed rule, we received 87 public comments from state Medicaid agencies, provider associations, providers, and other interested parties. The following is a brief summary of each proposed provision, a summary of the public comments that we received related to that proposal, and our responses to the comments.

A. General Comments on the Proposed Rule

In addition to the comments we received on the proposed rule's discussion of specific aspects of the State DSH Allotment Reductions (which we address later in this final rule), commenters also submitted the following more general observations on the reductions. A discussion of these

comments, along with our responses, appears below.

Comment: Many commenters expressed appreciation for the overall approach of the proposed rule. Some commenters expressed support that the statutory DSH reductions are implemented through reductions to DSH allotment instead of reductions to the Federal Medical Assistance Percentage (FMAP) for states.

Response: The final rule implements annual aggregate reductions in federal DSH allotments in accordance with the statutory direction and does not modify the FMAP for states.

Comment: Many commenters expressed support for delaying the implementation of the annual aggregate reductions to state DSH allotments through Congressional legislation adopting the President's Budget for Fiscal Year (FY) 2014 legislative proposal or other legislation such as the House Bill H.R.1920—DSH Reduction Relief Act of 2013. The commenters provided various reasons for the requested delay including the need for sufficient time for the full implementation of Affordable Care Act and potential implications of significant changes to the number of uninsured individuals and Medicaid individuals after implementation of the Affordable Care Act. Additionally, one commenter recommended that the DSH allotment reductions remain in full effect as legislated and proposed.

Response: We note that the FY 2014 President's Budget proposes a legislative change to delay the start of the Medicaid DSH allotment reductions while reallocating the scheduled \$500 million aggregate reduction to FY 2016 and FY 2017. In the absence of a legislative change, the aggregate reductions in federal DSH funding will begin with FY 2014 as required by current law. HHS has no flexibility to institute a delay of the DSH allotment reductions without congressional action.

Comment: A few commenters stated that states should retain flexibility in design of their DSH programs and how DSH payments are targeted to hospitals as long as funds are spent on patient care.

Response: This final rule will not affect the considerable flexibility afforded states in setting DSH state plan payment methodologies to the extent that these methodologies are consistent with section 1923(c) of the Act and all other applicable statute and regulations. States will retain the ability to preserve existing DSH payment methodologies or to propose modified methodologies by submitting state plan amendments. Although the final rule implements

statutory direction to impose larger percentage reductions on states that do not target their DSH payments on hospitals with high volumes of Medicaid inpatients and on states that do not target their DSH payments on hospitals with high levels of uncompensated care, states will retain the flexibility to make payments that are both consistent with section 1923(c) of the Act, and within reduced DSH allotment amounts.

Comment: Many commenters expressed support for the proposal for an initial DHRM that would be applicable only for the first 2 years during which the DSH funding reductions are in effect.

Response: We have finalized the DHRM only for FY 2014 and FY 2015.

Comment: Some commenters expressed general opposition to the Medicaid DSH allotment reductions required by statute citing, in part, the timing and amounts of the reductions. Another commenter opposed the proposed rule because it would result in a reduction of DSH payments.

Response: Federal statute requires annual aggregate reductions in federal DSH funding that begin with FY 2014. Federal DSH allotments will remain available at reduced levels for states to continue to make DSH payments to hospitals that serve a disproportionate share of low-income individuals and qualify for DSH payments under federal and state requirements. As noted above, the FY 2014 President's Budget proposes a legislative change to delay the start of the Medicaid DSH allotment reductions, but without a change in law, these final regulations will implement the reductions beginning with FY 2014.

Comment: Some commenters expressed support for the Medicaid DSH program and recommended that Medicaid DSH payments continue to ensure that hospitals are able to provide uncompensated care for uninsured individuals.

Response: The proposed rule does not eliminate DSH payments or affect state flexibility in setting DSH payments. The rule implements annual aggregate reductions in federal DSH funding for FY 2014 and FY 2015. For FY 2014 and thereafter, federal DSH allotments will remain available at reduced levels for states to continue to make DSH payments to hospitals that serve a disproportionate share of low-income individuals and qualify for DSH payments under federal and state requirements.

Comment: Some commenters recommended that Medicaid DSH allotments be restored if expanded

health care coverage resulting from the Affordable Care Act does not occur.

Response: While the statute specifies annual reduction amounts independent of the extent to which expanded health care coverage resulting from the Affordable Care Act occurs, we are confident that health insurance coverage will increase significantly as a result of the Act. The final rule implements provisions of the federal statute relating to federal DSH funding for FY 2014 and 2015.

Comment: A commenter expressed concern that CMS would not have sufficient time to review, consider, and incorporate state feedback based on public comments on the proposed rule and calculate state DSH allotments for FY 2014 in a timely manner.

Response: We reviewed and considered public comment carefully and thoroughly, and issued this final rule in a timely manner incorporating input from public comment. Additionally, we anticipate timely calculating DSH allotments and state-specific reductions for FY 2014.

Comment: A few commenters questioned our regulatory interpretation of the provisions specified in section 1923(g)(1)(a) of the Act. Regulatory policy requires that all revenue received by a hospital for providing services to Medicaid-eligible individuals with an additional source of third-party coverage be offset against the cost of providing such services when calculating the hospital-specific DSH limit. These commenters requested that we amend these regulations to specify that revenues received by a hospital from third party coverage for services provided to Medicaid-eligible individuals must only offset costs of providing such services to the extent of the Medicaid payment for purposes of calculating the hospital-specific limit and DSH qualification.

Response: This regulation does not address the calculation of hospital-specific DSH payment limits under section 1923(g) of the Act; it only addresses the statutorily-required Medicaid DSH allotment reductions. Changes to existing DSH calculation rules are outside the scope of this rule.

Comment: One commenter submitted a comment regarding the Medicare DSH program.

Response: Comments on the Medicare DSH program are outside the scope of this rule on Medicaid DSH allotment reductions and were addressed in separate rulemaking issued by us in August of this year.

Comment: One commenter recommended that we analyze state-by-state Medicaid and Medicare payment

differentials to lower DSH allotment reduction amounts for states with payment disparity between the two programs. The commenter also recommended that we offset Medicaid DSH reduction amounts for states that have global, risk-based payment arrangements.

Response: The Medicaid and the Medicare programs are distinct programs authorized by different sections of the statute and the Medicare and Medicaid DSH rules have somewhat different purposes and statutory directives. The Affordable Care Act directed the manner in which Medicaid DSH reductions should be implemented. As directed by statute, the final DHRM imposes larger percentage reductions on states that do not target their DSH payments on hospitals with high levels of uncompensated care. Uncompensated care cost, as defined in this final rule, already includes the amount Medicaid payments fall short of hospital costs (the Medicaid shortfall). The final rule's treatment of Medicaid shortfall is consistent with other existing statutory and regulatory Medicaid DSH definitions of uncompensated care cost.

We are committed to supporting innovative care delivery models and payment models with potential to improve care, improve health, and reduce costs, and states can structure their DSH funding to help promote those goals. We encourage states and providers to contact CMS to obtain more information regarding opportunities to implement innovative care delivery models and payment models.

Comment: Many commenters recommended that we finalize the provisions of the January 18, 2012 proposed rule entitled, "Medicaid Disproportionate Share Hospital Payments—Uninsured Definition." That proposed rule would define "individuals who have no health insurance (or other source of third party coverage) for the services furnished during the year" for purposes of calculating the hospital-specific DSH limit on a service-specific basis rather than on an individual basis.

Response: Comments on the January 18, 2012 proposed rule are outside the scope of the proposed rule on Medicaid DSH allotment reductions and will be finalized in future rulemaking.

Comment: Several commenters requested clarification regarding how state-specific DSH allotment reductions in the proposed rule would affect the determination of the limit on Medicaid DSH payments to institutions for mental diseases (IMD). Some of the commenters recommended that we proportionately

reduce the IMD DSH limit based on the aggregate DSH allotment reduction. One commenter expressed support for state flexibility in determining the effects of the aggregate DSH allotment reductions on the IMD DSH limit.

Response: Effective for FY 2014 and FY 2015, we will calculate the IMD DSH limit under section 1923(h) of the Act based on the DSH allotment after reductions implemented by the final rule to ensure that the IMD limit experiences a corresponding reduction consistent with the overall reductions in annual state DSH allotments.

Comment: Some commenters requested that we clarify when and how we will recoup state-specific DSH allotment reduction amounts from states.

Response: The final rule implements aggregate reductions in federal funding for DSH payments through reductions in annual state-specific DSH allotment reductions in accordance with section 1923(f)(7) of the Act. This section requires the use of a DHRM to determine the percentage reduction in each annual state DSH allotment to achieve the required aggregate annual reduction in federal DSH funding; there is no "recoupment" process because the DSH reductions are prospective, not retrospective.

Comment: One commenter requested clarification on how the amount of the FY 2014 unreduced DSH allotment for Tennessee and for the State of Hawaii for FY 2014 as included in the proposed rule was determined, and how the low-DSH state status for these state was determined.

Response: The amounts of the states' unreduced DSH allotments and the treatment of the states' low DSH status, as reflected in the Table 1 of the proposed rule, were only for the purpose of illustrating the DSH Health Reform Methodology for all states. Such amounts were determined in accordance with the existing methodology for determining the amounts of states' unreduced fiscal year DSH allotments. For this purpose, and in accordance with the existing methodology for determining states' unreduced allotments, the illustrative unreduced DSH allotments for FY 2014 in Table 1 of the proposed rule were based on the states' FY 2013 DSH allotments. Those allotments were increased by the estimated percentage increase in the consumer price index for all urban consumers (CPIU) for FY 2013.

As noted by the commenter, the current statute at section 1923(f)(6)(A) of the Act does not authorize a FY 2014 DSH allotment for the State of Tennessee. However, for the state of

Hawaii, the current statute at section 1923(f)(6)(B)(iii)(II) of the Act does authorize a FY 2014 DSH allotment for such state. Furthermore, such provision explicitly indicates that Hawaii shall be treated as a low-DSH state.

In summary, a FY 2014 DSH allotment for the State of Tennessee and the State of Hawaii was included in Table 1 of the proposed rule for illustrative purposes only. However, an allotment for the State of Tennessee would be available only if the statute was amended to provide for a FY 2014 DSH allotment for the state. In addition, a statutory amendment would be needed for Tennessee to be considered a low-DSH state.

B. DHRM Overview

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

The proposed DHRM utilized available data and a series of interacting calculations that result in the identification of state-specific reduction amounts that, when summed, equal the aggregate DSH allotment reduction amount identified by the statute for each applicable year. The proposed DHRM accomplished this through the summarized steps discussed in the proposed rule (78 FR 28555). In addition, we solicited public comment and input regarding alternate assignments. We also solicited comments on how these weights would impact specific hospital types. The manner in which each of these factors were considered and calculated in the proposed DHRM was described in greater detail in the proposed rule (78 FR 28555).

Comment: One commenter recommended corrections and clarification corrections to multiple terms defined in § 447.294(b).

Response: We addressed the need for technical correction and clarification by modifying the language of § 447.294(b) in this final rule. Specifically, we modified the definitions in § 447.294(b) for "Mean high level of uncompensated care factor (HUF) reduction percentage," "State group," "Total Medicaid cost," and "Uncompensated care costs" by correcting a typographical error and adding clarifying language.

Comment: One commenter recommended that CMS clarify for which years states are required to submit annual MIUR data as proposed at § 447.294(d).

Response: We are finalizing § 447.294(d) to include additional clarifying language regarding the required state submission of MIUR data. We finalized this section to specify that states must initially provide the data for following Medicaid State Plan Rate Years (SPRY) as defined in § 455.301: 2008, 2009, 2010, 2011 by June 30, 2014. States must also provide this data for each subsequent SPRY to CMS by June 30 of each year. To determine which SPRY data must be submitted, subtract three years from the calendar year in which the data is due. This means that the SPRY 2012 data must be submitted to CMS by June 30, 2015.

Comment: One commenter requested changes to § 447.294(f) to clarify that the state-specific DSH allotment reduction amounts in the proposed rule only applies to FY 2014 and FY 2015 DSH allotments.

Response: We are finalizing § 447.294(f) to specify that the state-specific DSH allotment reduction amounts in the proposed rule only applies to FY 2014 and FY 2015 DSH allotments.

Comment: One commenter recommended corrections to multiple instances when § 447.294(e)(10) was mistakenly referenced instead of § 447.294(e)(12). The commenter also noted that § 447.294(e)(10) mistakenly refers to the "HMF" instead of the "HUF."

Response: We are correcting these references in this final rule.

Comment: Many commenters expressed support that the proposed rule would not reflect state decisions to implement the new coverage group, would not cause undue harm to states that have not implemented or not decided to implement the new coverage group, and that the DHRM is only for the first 2 years during which the DSH funding reductions are in effect to allow continued evaluation of potential implications for accounting for coverage expansion in the DHRM.

Response: We intend to address the issue more completely in separate rulemaking for DSH allotment reductions for FY 2016 and thereafter.

Comment: Some commenters expressed support that the proposed DHRM does not reward states that do extend coverage to low-income adults under section 1902(a)(10)(A)(i)(VIII) of the Act. A few of these commenters suggested that CMS develop a mechanism in the DHRM to ensure that

states that do not extend coverage to low-income adults under section 1902(a)(10)(A)(i)(VIII) of the Act do not receive a lower DSH reduction as a result of their decision.

Response: Currently, we do not have data or other information on the relative impacts that would result from state decisions to implement the new coverage group, and thus, we proposed a DHRM only for the first 2 years during which the DSH funding reductions are in effect. The data that the reductions are based on for the first two years will not reflect state decisions to implement the new coverage group. Such data will be available in 2016. We intend to address this issue more completely in separate rulemaking for DSH allotment reductions for FY 2016 and thereafter including consideration of proposals that would take account of the decisions of states to expand coverage.

Comment: A few commenters expressed concern that the states that implemented various health reforms, including expanding Medicaid eligibility, prior to enactment of the Affordable Care Act would be unfairly penalized by the DHRM and would be forced to subsidize those states that have opted not to expand coverage. One of the commenters suggested that CMS modify the uninsured data to reflect the anticipated decrease in the uninsured for states that have indicated their intent to, but have not yet begun to, extend coverage to low-income adults under section 1902(a)(10)(A)(i)(VIII) of the Act.

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

As discussed in the proposed rule, implementation of the new coverage group is expected to affect the amount of uncompensated care and the percentage of uninsured individuals within states. Generally, we expect that states that do not implement the new coverage group would have relatively higher rates of uninsured, and more uncompensated care than states that adopt the new coverage group. We also recognize that there are other factors that affect state rates of uninsurance, including coverage differences among states prior to the implementation of the Affordable Care Act. Because there is a fixed amount of DSH funding, states

that implement the new coverage group would likely experience a reduction in DSH funding that would be greater than if all states had taken such action. Hospitals in those states would similarly be disadvantaged. However, these effects would not be experienced until after FY 2014 and FY 2015 based on current data reporting timelines. Accordingly, and considering the limits on funding for Medicaid DSH in the Affordable Care Act, we intend to account for the different circumstances among states in the formula in future rulemaking when the relevant data will be available.

For FY 2014 and 2015, we are finalizing the proposal to establish a DHRM that does not include a method to account for differential coverage expansions in Medicaid. We intend to address this issue more completely in separate rulemaking for DSH allotment reductions for FY 2016 and thereafter.

Comment: Many commenters expressed support for the uninsured percentage factor (UPF) calculation and another requested that the DHRM incorporate an adjustment into the UPF calculation to reduce the number of uninsured individuals in states that extend coverage to low-income adults under section 1902(a)(10)(A)(i)(VIII) of the Act so as to not unfairly penalize states that do not extend coverage to the new adult group. Another commenter asked that CMS create a separate DSH pool that would allocate funds directly to hospitals with high levels of uncompensated care in states that do not extend coverage to low-income adults because the hospitals would not benefit from the Medicaid coverage expansion. An additional commenter requested that CMS consider accounting for potential additional Medicaid payment shortfall, in addition to uninsured-related uncompensated care, when determining the relative impacts that would result from state decisions to implement the new low-income adults coverage group. Another commenter stated that CMS did not specify the data sources that DHRM would rely on to determine annual state-specific DSH allotment reduction amounts and expressed concern that the proposed rule states that the data used will reflect differential state decisions to implement the new low-income adults coverage group under section 1902(a)(10)(A)(i)(VIII) of the Act.

Response: We disagree that the proposed methodology would unfairly penalize states that do not extend coverage to low-income adults under section 1902(a)(10)(A)(i)(VIII) of the Act. The data that the reductions are based on for these 2 years will not reflect state

decisions to implement the new coverage group. Data reflecting the effects of the decision to implement the new coverage group may not be available to consider the impact of such a decision until 2016. We intend to address this issue more completely in separate rulemaking for DSH allotment reductions for FY 2016 and thereafter.

Additionally, we intend to publish a separate DHRM technical guide that provides information regarding the DHRM calculation, including the additional information regarding data sources.

Comment: Several commenters recommended that CMS ensure through future rulemaking that states that extend coverage to low-income adults under section 1902(a)(10)(A)(i)(VIII) of the Act do not receive increased DSH allotment reductions as a result of anticipated reductions in uninsurance rates. A few other commenters recommended that CMS ensure through future rulemaking that states that do not extend coverage to low-income adults under section 1902(a)(10)(A)(i)(VIII) of the Act do not receive increased DSH allotment reductions as a result of anticipated reductions in uninsurance rates.

Response: We intend to address this issue more completely in such separate rulemaking for DSH allotment reductions for FY 2016 and thereafter.

Comment: One commenter indicated that the proposed rule favors states that do not implement the new low-income adults coverage group under section 1902(a)(10)(A)(i)(VIII) of the Act by not relying on uninsured data that would be available reflecting the differential decisions by states to adopt the new adult coverage group. The commenter indicates that CMS is violating statute by not relying on uninsurance data from “the most recent year for which the data are available.” Another commenter requested that we specify which year’s United States Census Bureau’s American Community Survey (ACS) data we will use for the DHRM and is concerned that the use of recent data will adversely affect states implementing the new low-income adults coverage group.

Response: We disagree that the proposed methodology favors states that do not implement the new low-income adults coverage group under section 1902(a)(10)(A)(i)(VIII) of the Act or that the proposed methodology would violate statutory provisions. The uninsured data is derived from the 1-year estimates data of the number of uninsured identified by the ACS. The statute references use of uninsured data from the United States Census Bureau and the methodology relies on the most

recent available data. The data from the ACS will not be available for the period including January 1, 2014, or later until after the calculation of the DSH allotment reduction amounts for both FY 2104 and FY 2015. Therefore, because of the lag in the data, this final rule will rely on uninsured individual data for periods prior to January 1, 2014.

Comment: One commenter stated that the DHRM in the proposed rule would violate the statute by separating states into state groups based on their status as low-DSH states. The commenter’s suggested violation is based on not following the statutory language directing “smaller”, not the “smallest” reductions for low-DSH states and the language that requires the “largest” percentage reductions for states that have the lowest percentage of uninsured individuals and do not target DSH payments to hospitals with high levels of Medicaid inpatients and high levels of uncompensated care.

Response: We disagree that the proposed methodology violates statutory provisions. The methodology in the proposed rule, which we are adopting in this final rule, imposes smaller percentage reductions on low-DSH states compared to non-low DSH states and, within each state group, imposes larger percentage reductions on states that have the lowest percentages of uninsured individuals and on states that do not target their DSH payments to hospitals with high volumes of Medicaid inpatients and high levels of uncompensated care.

Comment: A commenter recommended that CMS implement the statutory DSH allotment reductions through pro rata reductions based on the size of the existing DSH allotment instead of relying on the five factors identified in the statute. The commenter also offers an alternative through use of the pro rata method for half of the allotment reduction amount and using the five statutory factors for the remaining amount. The commenter believes that the pro rata reductions would take into account the current DSH funding structure and would be less disruptive.

Response: Section 1923(f)(7)(B) of the Act establishes five factors that must be considered in the development of the DHRM, and in the DHRM which we proposed and are making final, we give weight to each of those five factors. The five factors implicitly take into account the size of the existing state DSH allotments, and the reduction is applied to the existing state DSH allotment.

Comment: A commenter recommended that CMS incentivize states to target more DSH payment to

hospitals with high volumes of Medicaid inpatients and high levels of uncompensated care.

Response: The statute requires that the DHRM methodology impose larger percentage DSH reductions on states that do not target their DSH payments on hospitals with high volumes of Medicaid inpatients and high levels of uncompensated care. While states have considerable flexibility in determining DSH payments, we believe that the statutory provision as implemented by DHRM will promote state targeting of DSH payments to hospitals with high volumes of Medicaid inpatients and hospitals with high levels of uncompensated care.

Comment: Two commenters recommended that the DHRM should first reduce unspent DSH allotment amounts prior to imposing additional reduction amounts to protect states that use their full DSH allotment.

Response: We did not propose to reallocate unreduced DSH allotments calculated under section 1923(f) of the Act. The suggested method could serve to penalize unfairly states that do not currently expend their entire DSH allotment. We are finalizing the structure of proposed DHRM that considers five factors identified by section 1923(f)(7)(B) of the Act when determining state-specific allotment reduction amounts.

Comment: A commenter recommended that the DHRM should avoid imposing retroactive reductions to state DSH allotments and instead establish prospective DSH allotment reductions adjustments that rely on final or completed data from previous years.

Response: The final rule establishes prospective DSH allotment reductions based on the most recent prior year data and does not impose retroactive allotment adjustments.

Comment: A commenter expressed concern that the DHRM relies on existing unreduced DSH allotments as the basis for application of the DHRM because the allotments are highly inequitable. The commenter recommended that CMS reallocate DSH allotments based on states’ uncompensated care costs prior to applying the annual DSH allotment reductions.

Response: The DHRM builds upon the existing unreduced DSH allotments because the statutory DHRM authority does not authorize reallocation of state DSH allotments under section 1923(f) of the Act. This section of the Act establishes the specific methodology required for calculating annual state DSH allotments. Although there have been some special rules for calculating

DSH allotments for particular years or sets of years, section 1923(f)(3) of the Act establishes a general rule that state DSH allotments are calculated on an annual basis in an amount equal to the DSH allotment for the preceding FY increased by the percentage change in the consumer price index for all urban consumers for the previous FY. Neither the statute nor this rule affects this calculation.

Uncompensated care costs are a factor under the DHRM in determining state-specific allotment reduction amounts because the statute directs that the DHRM impose larger percentage DSH allotment reductions on states that do not target DSH payments on hospitals with high levels of uncompensated care. But this factor does not reallocate existing DSH allotments, and this rule finalizes the use of existing unreduced DSH allotments as proposed.

Comment: Some commenters expressed concern that the application of the High Volume of Medicaid Inpatients Factor (HMF) and High Level of Uncompensated Care Factor (HUF) would not be consistent with the stated intention of those two factors. The commenters recommended that the proposed DHRM should consider any state DSH payment amount made to a hospital with either high Medicaid volume or high levels of uncompensated care as properly targeted for both the HMF and HUF.

Response: We disagree with the commenters that the proposed application of the HMF and HUF would be inconsistent with the stated intention of those two factors, which are discussed further in sections E. and F. of this rule. The factors are designed and implemented to ensure that the DHRM imposes larger percentage DSH allotment reductions on states that do not target DSH payments on hospitals with high levels of uncompensated care and on states that do not target DSH payments on hospitals with high volumes of Medicaid inpatients. The HMF independently evaluates how states target DSH payments to high Medicaid volume hospitals and the HUF independently evaluates how states target DSH payments to hospitals with high levels of uncompensated care. The allotment reduction amount will be mitigated under both the HMF and HUF for DSH payment amounts that states target to hospitals with both a high volume of Medicaid inpatients and a high level of uncompensated care.

Comment: One commenter recommended that any overpayment amount identified through annual independent certified DSH audits conducted as required by section 1923(j)

of the Act that is not redistributed to other DSH hospitals in accordance with the approved Medicaid state plan count toward the aggregate annual DSH allotment reductions prior to applying the DHRM. Another commenter recommended that we account for redistributions that would have occurred if the data is outside of the regulatory transition period and requested clarification on how redistributions would be accounted for after the transition period.

Response: This rule concerns only the DSH allotment reductions under section 1923(f)(7) of the Act, as added by section 2551 of the Affordable Care Act, and this comment is outside the scope of this rule. We view the treatment of the findings of the annual independent certified audits and reports required by section 1923(j) of the Act and implementing regulations as separate from the DSH allotment reductions directed by the Act.

Comment: One commenter recommended that CMS add an additional factor to the DHRM based on whether a state is over or under the median amount of Medicaid DSH allotment per uninsured individual. The commenter stated that the proposed DHRM does not address the existing disparity in the relationship among state's DSH allotment relative to the number of uninsured individuals and that the DHRM causes this relationship to be further out of balance. The commenter believes that the inequitable relationship is furthered by the proposed DHRM, and noted that the illustrative example displayed Florida as having a 4.74 percent allotment reduction while Louisiana had a 3.46 percent reduction.

Response: Although the proposed DHRM does not alleviate all potential differences among states in existing unreduced DSH allotments, the DHRM does provide potential relief. While the statutory provisions implemented by this final rule do not direct CMS to reallocate unreduced DSH allotments calculated in section 1923(f) of the Act, each of the five DHRM factors do take into account the size of the existing state DSH allotments. Most notably, the Low DSH Adjustment Factor (LDF) imposes smaller percentage reductions on low DSH states that historically have received lower DSH allotments relative to their total Medicaid expenditures than non-low DSH states.

Additionally, we do not believe that the commenter's example demonstrates that the proposed DHRM will necessarily further the disparity among states' uninsured per capita DSH allotment amounts. Although states

with smaller unreduced allotments may receive larger percentage reductions than states with larger unreduced allotments, the final DHRM does account for the size of state allotments prior to reduction.

1. Factor Weighting

Comment: Many commenters expressed support for CMS's assignment of a 33 and $\frac{1}{3}$ percent weight to the Uninsured Percentage Factor (UPF) and a 66 and $\frac{2}{3}$ percent combined weight for the two DSH payment targeting factors (a 33 and $\frac{1}{3}$ percent weight for the HUF, and a 33 and $\frac{1}{3}$ percent weight for the HMF). The commenters indicated that this was the most reasonable approach for assigning factor weights.

Response: We incorporated this weighting in the final rule. We intend to continue to monitor the impact of the weighting methodology for FY 2014 and FY 2015 and will reevaluate this approach for future rulemaking.

Comment: A few commenters recommended that CMS increase the weight of the HUF and reduce the weight of the HMF, stating that the weighting accounts for the care provided to Medicaid hospitals is duplicated or unbalanced. One of the commenters believes that the alternate weighting would compensate for the fact that both the HMF and the HUF incorporate Medicaid data, whereas uninsured care is only reflected in the HUF.

Response: We recognize that relationships among the data used in the UPF, HMF, and HUF exist; however, we view the DHRM factors as distinct and non-duplicative. The UPF, HMF, and HUF each compare data among states using three core measures: percentage of uninsured individuals, DSH payments targeted to hospitals with high volumes of Medicaid inpatients, and DSH payments targeted to hospitals with high levels of uncompensated care, respectively. The interactions among these related factors are varied and inconsistent. Depending on the cost, payment, and volume of Medicaid and uninsured patients, a hospital with a high volume of Medicaid inpatients may have no uncompensated care cost. Alternatively, a hospital with low Medicaid volume may have high uncompensated care costs which may be a function, in part, of the high percentage of uninsured individuals in the state. The fact that the HMF and the HUF both rely on Medicaid data is not dissimilar to the UPF and HUF relying on uninsured data.

Comment: One commenter recommended that CMS increase the weight of the UPF, based on the

importance of DSH payments to hospitals that serve patients regardless of their ability to pay.

Response: We appreciate the important role of hospitals that serve patients regardless of their ability to pay. However, we believe that the weighting in the proposed rule is a reasonable approach that gives the statutory factors equal weight and have incorporated this method in the final rule. We intend to continue to monitor the impact of the weighting methodology for FY 2014 and FY 2015 and will reevaluate this approach for future rulemaking.

Comment: A commenter recommended that CMS decrease the weight of the UPF to incentivize states to extend coverage to low-income adults under section 1902(a)(10)(A)(i)(VIII) of the Act.

Response: As noted above, because of data lags, we do not have the data to support an approach in the first 2 years that reflects state decisions to implement the new coverage group, and thus, we proposed and are finalizing a DHRM only for the first 2 years during which the DSH funding reductions are in effect. We intend to address this issue more completely in separate rulemaking for DSH allotment reductions for FY 2016 and thereafter.

Comment: One commenter recommended that CMS decrease the weight of the HUF to recognize the benefits of DSH payments in certain states that are designed to exclusively offset uninsured costs and to promote access to care.

Response: We appreciate the important role of hospitals that serve uninsured patients. The proposed DHRM would promote the state targeting of DSH payments to hospitals with high levels of uncompensated care costs, which include the cost incurred providing services to the uninsured. A state that targets DSH payments to hospitals based on the volume of uncompensated care costs for the uninsured would most likely benefit from the proposed methodology. We believe that the weighting in the proposed rule is a reasonable approach that incentivizes states to target their DSH payments and have incorporated this method in the final rule. We intend to continue to monitor the impact of the weighting methodology for FY 2014 and FY 2015 and will reevaluate this approach for future rulemaking.

Comment: Two commenters recommended that CMS decrease the weight of the HUF due to the limitations of the formula, lack of complete data, and the potential for paradoxical

outcomes when comparing hospital levels of uncompensated care.

Response: Due to data limitations, we recognize that the HUF formula may produce very limited outcomes due to the limited data available at this time. However, we expect any impact resulting from such outcomes to be minimal and we believe that the proposed method represents the most reasonable method for determining hospitals with high levels of uncompensated care costs given limited data availability. Therefore, we have incorporated the proposed weighting method in the final rule. We intend to continue to monitor the impact of the weighting methodology for FYs 2014 and 2015 and will reevaluate this approach for future rulemaking. Additionally, by collecting the total cost, we are positioned through separately issued rulemaking for FY 2016 to substitute total cost for the denominator in step one of the HUF calculation to optimize the method for determining hospitals with high levels of uncompensated care.

Comment: Some commenters recommended that CMS reduce the weight of the UPF to zero at least until such time as CMS has data to measure the impact of state decisions to implement the new low-income adults coverage group under section 1902(a)(10)(A)(i)(VIII) of the Act.

Response: We believe that the proposed weighting is the most reasonable approach and have finalized this method in this final rule. We intend to continue to monitor the impact of the weighting methodology for FY 2014 and FY 2015 and will reevaluate this approach for future rulemaking.

Comment: One commenter expressed concern that CMS assigned any weight to the HMF because a hospital having high Medicaid inpatient days do not always indicate large Medicaid shortfalls and uncompensated care costs, because some states have relatively higher average MIURs than other states, and because relying on Medicaid days is inconsistent with federal, state, and industry efforts to reduce inpatient hospital use and lower readmissions. The commenter recommends that CMS assign zero weight to the HMF and instead only consider hospital's actual Medicaid shortfall.

Response: We have finalized the rule to continue to assign weight to the HMF. In promoting states to target current and future DSH payments to hospitals that have higher volumes of Medicaid inpatients, we believe that the HMF accomplishes its design and is consistent with the statutory direction that the DHRM impose larger percentage

reductions on states that do not target their DSH payments on hospitals with high volumes of Medicaid inpatients. Section 1923(f)(7)(B)(i)(II)(aa) of the Act defines hospitals with high volumes of Medicaid inpatients as those defined in section 1923(b)(1)(A) of the Act.

Comment: A few commenters urged CMS to ensure that the two targeting factors do not penalize states that align DSH qualifying criteria very closely with federal deeming criteria at section 1923(b) of the Act. Specifically, the commenters recommended that the DHRM account for differences among states based on how states established their DSH qualifying criteria or target payments to hospitals that are deemed DSH based on low-income utilization rate (LIUR) alone. One commenter stated that states that primarily pay hospitals that are federally deemed hospitals will be negatively affected if the substantial payments are made to hospitals deemed based on the LIUR threshold, not the MIUR threshold.

Response: We have finalized the proposed DHRM that promotes state targeting of payments to hospitals that would qualify for DSH payments based on MIUR deeming requirements defined in section 1923(b)(1)(A) of the Act. This final rule establishes this targeting factor consistent with the statutory direction to impose larger percentage reductions on states that do not target their DSH payments on hospitals with high volumes of Medicaid inpatients and do not target their DSH payments on hospitals with high levels of uncompensated care. The HMF provides mitigation of the state-specific DSH reduction amount for states that have been targeting and would in the future target DSH payments to these federally deemed hospitals. Hospitals with high LIURs may also have high levels of uncompensated care costs. If those LIUR-deemed hospitals have high levels of uncompensated care, the HUF will provide mitigation of the state-specific DSH reduction amount for states that have been targeting and would in the future target DSH payments to those hospitals.

Comment: A commenter recommended that the DHRM impose a sliding scale for HMF and HUF reduction amounts based on the amount of aggregate state DSH payments received by DSH hospitals net of provider taxes compared to the unreduced DSH allotment.

Response: Medicaid DSH payment amount data sources used in the DHRM rely on existing federal statute and regulatory definitions of DSH payments. Changes to these existing definitions are outside the scope of this rule.

Comment: A few commenters recommended that we finalize our proposal to rely on state-specific thresholds when ranking hospitals for purposes of the HMF and HUF. One commenter stated that the method is a more accurate gauge of a hospital's true level of Medicaid volume and uncompensated care than a national comparison.

Response: We agree that the DHRM, including the HMF and HUF, is designed to employ the most equitable method for comparing how states target DSH payments for purposes of determining state-specific DSH allotment reduction amounts. We have finalized the HMF and HUF to rely on state-specific thresholds when ranking hospitals. However, we intend to continue to monitor the impact of the DHRM in effect for FY 2014 and FY 2015 and will reevaluate the DHRM for future rulemaking.

Comment: A commenter expressed general support for the DHRM and recommended that the final rule include a process to allow states to verify the calculation of the aggregate DSH payments made to non-high Medicaid volume hospitals used for the HMF and the calculation of the aggregate uncompensated care levels used for the HUF.

Response: To determine the aggregate DSH payments made to non-high Medicaid volume hospitals used for the HMF and the calculation of the aggregate uncompensated care levels used for the HUF, we utilize Medicaid DSH annual audit and reporting data required by section 1923(j) of the Act and implementing regulations. States submit this data annually to CMS. We appreciate the interest in ensuring that accurate data is used to calculate state-specific DSH allotment reductions; therefore, we recommend that states review this data to verify its accuracy prior to their annual submission of the data to CMS.

Comment: Some commenters requested clarity on the years of the DSH audit and reporting data used in the DHRM. One commenter also recommended that we clarify the meaning of usable form.

Response: For hospitals that receive DSH payments and are included in the DSH audit and reporting data, we proposed and are finalizing the use of the most recent complete DSH audit and reporting data for purposes of the DHRM. It requires considerable resources to review, compile, and consolidate DSH audit and reporting data. For purposes of this rule, we intend to use the most recent DSH audit and reporting data available at the time

of allotment reduction calculation based on the existing DSH audit and reporting process. Additionally, we intend to publish a separate DHRM technical guide that provides information regarding the DHRM calculation and associated data sources.

Comment: Some commenters indicated that a state excluded private hospitals from the DSH audit and reporting data for all years after SPRY 2009 and are concerned that this would adversely affect the calculation of the state-specific DSH allotment reduction for that particular state. One commenter recommended that we use SPRY 2008 DSH audit and reporting data and not data from other years for the DHRM for FY 2014 and FY 2015. Another commenter recommended that we require states to report DSH payments of zero for any hospitals that forfeit their DSH payments and are excluded from DSH audit and reporting requirements.

Response: If there are concerns regarding the accuracy of the DSH audit and reporting data submitted by states, including incorrectly excluded hospitals, we recommend that the interested parties work with the state and CMS through the DSH audit and reporting process. Federal statute and implementing regulations only require the reporting of information for hospitals receiving DSH payments in a particular year. If hospitals do not receive DSH payments, including those hospitals that have worked with their state to forego DSH payments, the state should not report information for those hospitals as part of the DSH reporting requirements.

Comment: One commenter recommended that we require states to submit Medicare provider numbers for all DSH hospitals.

Response: We are finalizing the proposal to collect Medicare provider numbers through the DSH audit and reporting process to align DSH hospital data from various sources, including DSH audit and reporting data and Medicare cost report data.

Comment: Some commenters requested that CMS publish all hospital-specific data used in the DHRM for all proposed and final rules relating to state-specific DSH allotment reductions for transparency, to facilitate data review and validation.

Response: We intend to publish a separate DHRM technical guide that provides information regarding the DHRM calculation and associated data sources.

Comment: Some commenters recommended that CMS allow all states to supplement and to revise DSH audit and reporting data after the state

submission of the audits and reports to CMS. Additionally, the commenter recommended the use of the last available data that relates to those hospitals that no longer participate in the DSH audit process.

Response: The final rule relies on DSH audit and reporting data as submitted by states in accordance with section 1923(j) of the Act and implementing regulations. The implementing regulations and associated policy guidance address circumstances in which the state should submit a corrected audit and report for a particular state plan rate year and when a state should include the adjustment in more recent years. States should follow existing guidance regarding when and how to submit corrected audits and report. For purposes of this rule, we intend to use the most recent complete national DSH audit and reporting data available at the time of allotment reduction calculation based on the existing DSH audit and reporting process.

Comment: Several commenters expressed concern regarding the use of DSH audit and reporting data for the DHRM. The commenters cited various reasons causing concern regarding data quality including the use of out-of-date data, the lag between DSH policy changes and audit and reporting data, the use of data used from a regulatory transition period, and the use of incomplete data. Some commenters recommended that CMS use uniform data wherever possible among all hospitals for use in the DHRM and that CMS consider weighting more heavily the factors that have the most accurate data. Another commenter recommended that we consider initiating a separate survey to determine uncompensated care costs for a more recent year.

Response: The Medicaid DSH audit and reporting data is the only comprehensive reported data available that is consistent with Medicaid program requirements. We have finalized reliance on this data in the DHRM because it represents the best available data that is consistent with existing program definitions. To date, we have received rich, comprehensive audit and reporting data from each state that makes Medicaid DSH payments. To facilitate the provision of high quality data, we provided explicit parameters in the 2008 DSH final rule and associated policy guidance for calculating and reporting data elements. The 2008 DSH final rule included a transition period in which states and auditors could develop and refine audit and reporting techniques. This transition period covered data reported relating to state

plan rate years 2005 through 2010. We recognize that the DSH audit and reporting data during this transition period may vary in its quality and accuracy from state to state and have finalized the collection of additional information that will allow us to ensure collection of the information necessary to best implement state-specific DSH allotment reductions beyond FY 2015. Consistent with ongoing efforts to ensure that the reported data is of the highest quality possible as we move through the transition period, we intend to issue additional detailed guidance to states by the end of CY 2013 that would be applicable to audits and reports due to us by the end of CY 2014.

Comment: Many commenters recommended that CMS use uncompensated care costs from worksheet S-10 from the CMS-2552-10 cost report when determining uncompensated care costs for purposes of the DHRM. The commenters cited various reasons for the recommendation including, the S-10's broader definition of uncompensated care costs, reduced state burden of reporting total cost directly to CMS. Many commenters also recommended that we modify worksheet S-10 to ensure meaningful use for purposes of the DHRM in future years. Citing quality concerns of reported data, some commenters also recommended against the worksheet S-10 of the CMS-2552-10 to determine uncompensated care costs for the DHRM. The commenters recommend that CMS develop an unspecified alternate source to determine uncompensated care costs.

Response: Worksheet S-10 of the CMS-2552-10 cost report does not define uncompensated care cost in a manner consistent with the existing Medicaid program definition under section 1923(g) of the Act. To ensure program consistency, the definition under section 1923(g) of the Act is also used for purposes of this rule.

Comment: A few commenters recommended that we utilize the Healthcare Cost Report Information System (HCRIS) to determine total hospital cost for the DHRM.

Response: We recognize that total hospital cost information is available from HCRIS. Data for all Medicaid DSH hospitals, however, is not in this database. A misalignment of Medicaid DSH audit and reporting data and Medicare hospital cost data also exists, so we have finalized our proposal for states to report provider numbers in their annual DSH audit and reporting submissions. We will continue to evaluate utilizing HCRIS data as a

potential source of total cost for purposes of future rulemaking.

Comment: Many commenters recommend that we rely on existing reporting mechanisms instead of requesting additional data from states, including obtaining total cost information directly from the Medicare cost reports rather than collecting directly from states through Medicaid DSH audits and reports. Some additional commenters recommended that we align the Medicaid and Medicare method for calculating and/or capturing cost.

Response: The Medicaid program and the Medicare program are separate programs authorized by different sections of the statute and while we try whenever possible to align the rules and reporting, it is not always possible to do so. To ensure efficient operations and to ease administrative burden on states and providers, we utilize information available to us through existing reporting. The DSH audit and reporting relies on existing financial and cost reporting tools currently used by all hospitals participating in the Medicare program and available state and hospital data. These documents include the Medicare 2552 cost report, audited hospital financial statements and accounting records, and information provided by the states' Medicaid Management Information Systems (MMIS) and the approved Medicaid State plan governing the Medicaid payments made during the audit period. The final rule requires the collection of additional information to facilitate the generation of usable data from existing mechanisms. The rule requires the calculation and collection of total cost information through cost report and Medicaid DSH audit and reporting processes to ensure data uniformity and consistency. Additionally, we will use provider numbers submitted annually by states through Medicaid DSH audits and reports to resolve a misalignment of Medicaid DSH audit and reporting data and Medicare hospital cost data.

Comment: Two commenters recommended that we use alternative data sources when determining total hospital costs for children's hospitals.

Response: We recognize that some children's hospitals may not file a Medicare 2552 cost report or may file a partial Medicare 2552 cost report. If a hospital does not file or files only a partial Medicare 2552 cost report, the state remains responsible for reporting the information which would have otherwise been available on the Medicare 2552 from each hospital to determine total cost. To meet federal DSH audit and reporting requirements,

states may require such hospitals to provide the same data to the state as if they were filing the Medicare 2552.

Comment: One commenter recommended that we publish a preliminary collection of data that would be used for the DHRM and allow an opportunity for data correction prior to the calculation of state-specific DSH allotment reduction amounts.

Response: To ensure efficient operations, to ease administrative burden on states and providers, and to ensure accurate reporting, the final rule utilizes information available to us through existing reporting mechanisms. The DSH audit and reporting relies on existing financial and cost reporting tools currently used by all hospitals participating in the Medicare program and available state and hospital data. All of these data sources are subject to audit, review, or certification prior to submission to CMS. These documents include the Medicare 2552 cost report, audited hospital financial statements and accounting records, and information provided by the states' MMIS and the approved Medicaid state plan governing the Medicaid payments made during the audit period. We intend to publish a separate DHRM technical guide that provides information regarding the DHRM calculation and its data sources.

2. Comments on Future Rulemaking

Comment: We received many comments providing recommendations and requested considerations for the DHRM after FY 2015. The comments included recommendations to modify the definition of uncompensated care costs, recommendations to conduct studies evaluating the impact of DSH allotment reduction implementation, recommendations on factor weighting, recommendations on data sources and data collection methods, requests for engagement of the provider community prior to future rulemaking, recommendations regarding state decisions to implement the low-income adults group, and recommendations to finalize future fiscal year's DHRMs in increments.

Response: We appreciate all comments and recommendations regarding future rulemaking. The Affordable Care Act provides an increase in coverage options available through the Marketplace and state Medicaid programs that will coincide with the DSH allotment reductions implemented through this rule. We intend to consider the valuable input from these comments and the information that will be available to us beginning in 2014 for determining the

methods for DSH allotment reductions for FY 2016 and thereafter.

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

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

We proposed to apply the Low DSH Adjustment Factor (LDF) by imposing a greater proportion of the annual DSH funding reduction on non-low DSH states. The factor is calculated and applied as discussed in greater detail in the proposed rule (78 FR 28555 through 28556). We received a number of public comments on the proposed Factor 1—LDF. A discussion of these comments, with our responses, appears below.

Comment: One commenter agrees that the Commonwealth of Pennsylvania is appropriately classified as a non-low DSH state, expressed uncertainty regarding the future status of Pennsylvania as a non-low DSH states, and opposed the DSH allotment reductions because a greater proportion of the funding reduction is imposed on non-low DSH states.

Response: We agree with the commenter that Pennsylvania was correctly classified as a non-low DSH state. The statute establishes the criterion in section 1923(f)(5)(B) of the Act to classify states as low-DSH. Regarding the comments in opposition to imposing greater reductions on non-low DSH states, the proposed and final rule are consistent with the statutory direction to impose a smaller percentage DSH allotment reduction on low DSH states.

Comment: One commenter expressed support that low DSH states do not receive a larger percentage reduction than all other states due to the interaction with other DHRM factor requirements directed by the statute.

Response: We appreciate the commenter’s support but note that while the proposed and final LDF is consistent with the statutory direction to impose a smaller percentage DSH allotment reduction on low DSH states,

it is possible that the overall reduction percentage may be higher for a low DSH state than a non-low DSH state on the basis of other factors identified by the statute.

Comment: One commenter opposed the LDF and indicated that the methodology used to calculate the LDF was flawed and creates substantial disparate treatment between low DSH states and non-low DSH states. Specifically, the commenter stated that it is inappropriate to use the mean unreduced DSH allotment as a percentage of Medicaid service expenditures as a measure to compare low DSH and non-low DSH state groups. The commenter estimated that some low DSH states have a higher mean unreduced DSH allotment as a percentage of Medicaid service expenditures than some non-low DSH states and that states with the greatest such percentages would not necessarily receive greater percentage reductions than other states. The commenter recommends that CMS use a fixed LDF of 50 percent.

Response: This final rule does not reallocate unreduced DSH allotments calculated in section 1923(f) of the Act or alleviate all potential differences among states in existing unreduced DSH allotments. The DHRM does provide potential relief by imposing smaller percentage reductions on low DSH states which historically have received lower DSH allotments relative to their total Medicaid expenditures than non-low DSH states. This historical difference serves as the basis for assigning the LDF value. Although we considered alternate methods for determining a value, we believe that the LDF best addresses this historical difference while adhering to statutory direction.

Comment: A commenter recommended that CMS not rely on estimated Medicaid services expenditures and instead rely on actual expenditures as the basis for calculating the LDF due to potential inaccuracy, particularly given the potential impact of states’ decisions to adopt the new low-income adult coverage group under the Medicaid program.

Response: We have modified the final rule to use actual expenditures instead of estimated expenditures. We believe that the use of actual expenditures for the affected year is a more appropriate method for capturing the relationship between state groups for the reduction year. Additionally, the impact of state decisions to adopt the new low-income adult coverage group will not be captured in the DHRM for FY 2014 or FY 2015.

Comment: One commenter identified an error in the proposed rule’s illustrative table of DSH allotment reductions because it misclassified Arkansas and Arizona.

Response: In the illustrative table in the proposed rule, we inadvertently transposed Arkansas and Arizona. We will ensure that this error does not occur when determining final state-specific DSH allotment reduction amounts.

Comment: One commenter requested clarification regarding the data sources used to calculate the LDF.

Response: We intend to publish a separate DHRM technical guide that provides information regarding the DHRM calculation, including the additional information regarding data sources.

D. Factor 2—Uninsured Percentage Factor (UPF)

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

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

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

The proposed UPF is determined separately for each state group as described in greater detail in the proposed rule (78 FR 28556). We proposed to utilize preliminary DSH

allotment estimates to develop the DSH reduction factors. We received a number of public comments on the proposed Factor 2—UPF. A discussion of these comments, with our responses, appears below.

Comment: Many commenters support the DHRM's identification of uninsured individuals based on 1-year estimates of the number of uninsured from the U.S. Census Bureau's American Community Survey.

Response: We are finalizing the use of 1-year estimates of the number of uninsured from the American Community Survey.

Comment: Many commenters expressed concern that the uninsured individual data used for the UPF may undercount the numbers of undocumented individuals as reported and estimated through the ACS.

Response: We received information from the Census Bureau in response to the comments. According to the Census Bureau, the foreign-born population includes anyone who is not a U.S. citizen at birth. This includes two groups: (1) Naturalized U.S. citizens; and (2) noncitizens. Noncitizens include lawful permanent residents (immigrants), temporary migrants (such as foreign students), humanitarian migrants (such as refugees and asylees), and persons not lawfully present in the United States.

The Census Bureau collects data from all foreign born who participate in its censuses and surveys, regardless of legal status. Thus, unauthorized migrants are included in ACS estimates of the total foreign-born population. However, the Census Bureau only asks foreign-born respondents if they are naturalized U.S. citizens or noncitizens, so it is not possible to tabulate separate estimates of unauthorized migrants using the ACS. The Census Bureau believes estimates of the foreign-born population in the ACS do include unauthorized immigrants. Accordingly, we have finalized our proposed use of ACS data without an adjustment in the uninsured data.

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

The third factor considered in the proposed DHRM is the High Volume of Medicaid Inpatients Factor (HMF) identified at section 1923(f)(7)(B)(i)(II)(aa) of the Act, which requires that the DHRM impose larger percentage DSH allotment reductions on states that do not target DSH payments to hospitals with the highest volumes of Medicaid inpatients. For purposes of the DHRM, the statute defines hospitals with high volumes of Medicaid patients as those defined in section 1923(b)(1)(A)

of the Act. These hospitals must meet minimum qualifying requirements at section 1923(d) of the Act and have an MIUR that is at least one standard deviation above the mean MIUR for hospitals receiving Medicaid payments in the state. Every hospital that meets that definition is deemed a disproportionate share hospital and is statutorily required to receive a DSH payment. The HMF, through the proposed DHRM, provides the mitigation of the DSH reduction amount for states that have been targeting and would in the future target DSH payments to these federally-deemed hospitals.

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

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

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

payments in the state reported separately.

The proposed HMF is a state-specific percentage that is calculated separately for each state group (low DSH and non-low DSH) as described in greater detail in the proposed rule (78 FR 28556 through 28557).

Section 1923(f)(7)(B)(i) of the Act specifies that the DHRM impose larger percentage reductions on states that do not target their DSH payments on hospitals with high volumes of Medicaid inpatients. Section 1923(f)(7)(B)(i)(II)(aa) defines hospitals with high volumes of Medicaid inpatients as those defined in section 1923(b)(1)(A) of the Act.

Comment: Many commenters expressed support for the HMF, including specific components of the HMF methodology.

Response: We appreciate the commenter's support and have finalized the HMF as proposed, unless otherwise specified.

Comment: One commenter recommended that CMS add additional protection for hospitals that have MIURs that are significantly in excess of one standard deviation above the mean MIUR for hospitals receiving Medicaid payments in the state because these hospitals are key public services hospitals.

Response: We agree that these hospitals are key public services hospitals. The threshold used in the DHRM for the HMF is expressly identified by statute. The HMF already considers any state DSH payments made to hospitals that are in excess of one standard deviation above the mean as payments that are targeted consistent with the statutory MIUR threshold. Therefore, we anticipate that DHRM will incentivize and promote state targeting of DSH payments to any hospitals exceeding this threshold, including those hospitals that significantly exceed it.

Comment: A few commenters recommended modifications to the definition used to determine high Medicaid volume hospitals. The recommendations include allowing Medicaid discharges in addition to Medicaid days as part of the determination process and weighting the methodology to include outpatient hospital services.

Response: The threshold used in the DHRM for the HMF to designate a high volume Medicaid hospital is expressly identified by statute. We believe that this threshold is appropriate and anticipate that the DHRM will incentivize and promote state targeting

of DSH payments to any hospitals exceeding this threshold.

Comment: One commenter supports the proposed HMF, but recommends that CMS add additional protection for any hospital that has an MIUR that is at least three standard deviations above the mean MIUR for hospitals receiving Medicaid payments in the state by mandating that states make DSH payments to such hospitals for their entire hospital-specific limit.

Response: We designed the DHRM to preserve the considerable flexibility afforded states in setting DSH state plan payment methodologies to the extent that these methodologies are consistent with section 1923(c) of the Act and all other applicable statute and regulations. Therefore, we are not adopting the commenter's recommendation. However, we will consider further targeting in future rulemaking.

Comment: One commenter recommended that the DHRM rely on MIUR data derived from the original DSH payment calculation instead of actual data derived from the Medicaid DSH audits and reports.

Response: The proposed and final rules do not rely on Medicaid DSH audit and reporting data for MIUR data. Instead, we will rely on MIUR information that we will collect from states on an annual basis outside of this rule.

Comment: One commenter requested clarification regarding which MIUR data we will use for the DHRM.

Response: We will rely on MIUR information that we collect from states on an annual basis outside of this rule. We have already initiated collection for applicable Medicaid state plan rate years. We also intend to publish a separate DHRM technical guide that provides information regarding the DHRM calculation, including the additional information regarding data sources.

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

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

Each state must develop a methodology to compute this hospital-specific limit for each DSH hospital in the state. As defined in section

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

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

The following data elements are used in the HUF calculation:

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

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

The HUF is a state-specific percentage that is calculated separately for each state group (low DSH and non-low DSH) as described in greater detail in the proposed rule (78 FR 28557).

We proposed to modify DSH reporting requirements to collect total hospital cost from Medicare cost report data for all DSH hospitals. Through separately issued rulemaking for FY 2016 and thereafter, we intend to substitute total cost for the denominator in step one of the HUF calculation above. Since total cost is unavailable at this time, we solicited comment on alternatives to the use of total uncompensated care cost as the denominator to alleviate this data issue.

Understanding potential data limitations and that the proposed methodology does not precisely distinguish how states direct DSH payments among hospitals that are identified as at or above the mean uncompensated care, we solicited comments on alternative methodologies regarding state targeting of DSH payments to hospitals with high levels of uncompensated care.

Comment: Many commenters expressed support for the HUF, including specific components of the HUF methodology.

Response: We have finalized the HUF as proposed, unless otherwise specified.

Comment: A commenter expresses concern that the DHRM would penalize states and some of their hospitals if states target their DSH payments based on indigent care levels alone, instead of on Medicaid factors.

Response: We have finalized the proposed DHRM that promotes state targeting of payments to hospitals that would qualify for DSH payments based on MIUR deeming requirements defined in section 1923(b)(1)(A) of the Act. The final rule establishes this targeting factor consistent with the statutory direction to impose larger percentage reductions on states that do not target their DSH payments on hospitals with high volumes of Medicaid inpatients and do not target their DSH payments on hospitals with high levels of uncompensated care. The HMF provides mitigation of the state-specific DSH reduction amount for states that have been targeting and would in the future target DSH payments to these types of hospitals. Hospitals with high levels of indigent care levels may also have high levels of uncompensated care costs. If those hospitals have high levels of uncompensated care, the HUF will provide mitigation of the state-specific DSH reduction amount for states that have been targeting and would in the

future target DSH payments to those hospitals.

Comment: Some commenters recommended that the DHRM remove DSH payments made to high volume Medicaid hospitals prior to determining the amount of DSH payments made to hospitals that are not targeted to hospitals with high levels of uncompensated care.

Response: We have finalized the proposed DHRM that promotes, through the HUF, state targeting of payments to hospitals with high levels of uncompensated care independent of the hospitals' status as a high volume Medicaid hospital. This final rule establishes this targeting factor consistent with the statutory direction to impose larger percentage reductions on states that do not target their DSH payments on hospitals with high levels of uncompensated care.

The DHRM, through the HMF, already provides mitigation of the state-specific DSH reduction amount for states that have been targeting and would in the future target DSH payments to high volume Medicaid hospitals. If DSH payments to those hospitals were also excluded for purposes of the HUF, the protection would be afforded to states even if the hospitals had low levels of uncompensated care. This is inherently counter to this factor, which is designed to promote state targeting of DSH payment to hospitals with high levels of uncompensated care costs. If the high Medicaid volume hospitals also have high levels of uncompensated care, the HUF will also provide additional mitigation of the state-specific DSH reduction amount based on state DSH payments targeted to these hospitals.

Comment: A few commenters stated that the proposed HUF properly accounts for hospital size, but does not adequately account for the amount of care provided to Medicaid and uninsured patients. The commenter recommends that we further adjust each hospital's uncompensated care level by adding an additional weight to each hospital based on each hospital's total Medicaid and uninsured costs when calculating the UPF.

Response: Though total hospital volume is accounted for, in part, by basing HUF reductions on the total payments not targeted to hospitals that have high levels of uncompensated care, we recognize that the proposed HUF does not provide for an ideal accounting of the volume of each hospital's amount of care provided to Medicaid and uninsured patients when determining which hospitals have high levels of uncompensated care. Regardless, we are concerned that adding an adjustment for

total Medicaid and uninsured volume would unfairly and adversely affect smaller hospitals. We have initiated a resolution to the identified volume concern by finalizing the collection of total cost data. We intend to substitute total cost for the denominator in step one of the HUF calculation to alleviate the identified concern for future periods.

Comment: Some commenters expressed concern that the HUF does not rely on an accurate measure of uncompensated care and may potentially produce paradoxical outcomes when comparing hospital levels of uncompensated care. One commenter agreed with the proposal that total cost would be a better denominator in step one of the HUF calculation, but recommended that CMS utilize Medicare cost report data to determine uncompensated care costs for FY 2014 and FY 2015.

Response: We recognize that the HUF may produce isolated paradoxical outcomes due to the limited data available at this time. However, we believe the method proposed does represent the most reasonable method for determining hospitals with high levels of uncompensated care costs given limited data availability. We expect any impact resulting from such outcomes to be minimal and we believe the method proposed represents the most reasonable method for determining hospitals with high levels of uncompensated care costs given limited data availability. Additionally, through separately issued rulemaking for FY 2016 and thereafter, we intend to substitute total cost for the denominator in step one of the HUF calculation to optimize the method for determining hospitals with high levels of uncompensated care.

We agree that total cost is a better denominator in step one of the HUF calculation. To address misalignment of Medicaid DSH audit and reporting data and Medicare hospital cost data, we have finalized our proposal for states to report provider numbers in their annual DSH audit and reporting submissions. Additionally, we have finalized the collection of total cost data, which will be audited consistent with other DSH audit and reporting data used by this proposed rule. We intend to utilize this information to determine the optimum method for calculating uncompensated cost for FY 2016 and thereafter.

Comment: One commenter expressed concerns that the HUF does not properly address the statutory direction to impose larger percentage reductions on states that do not target their DSH payments on hospitals high levels of

uncompensated care because Medicaid DSH audit and reporting data does not include all hospitals in a state.

Response: We recognize that the DSH audit and reporting data does not include uncompensated care information for all hospitals; however, the Medicaid DSH audit and reporting data represent the only existing uncompensated care cost data consistent with the existing statutory definition of uncompensated care cost used in determining the hospital-specific limit on FFP for DSH payments. We disagree with the commenter that the HUF does not address the statutory direction to impose larger percentage reductions on states that do not target their DSH payments on hospitals high levels of uncompensated care. The proposed and final HUF is designed to promote state targeting of DSH payments to hospitals with high levels of uncompensated care based on imposing reductions based on the payments to non-high level uncompensated care hospitals.

Comment: Two commenters requested clarification regarding the term "weighted mean" used for purposes of the HUF calculation.

Response: We have removed the term "weighted" when referencing means in the final rule to alleviate potential confusion. We intend to publish a separate DHRM technical guide that provides additional information regarding the DHRM calculation.

Comment: Two commenters recommended that we include bad debt, including unpaid copayments and deductibles, in the definition of uncompensated care costs used for purposes of the UPF. The commenter also recommended that CMS change the treatment of bad debt when calculating the hospital-specific DSH limit at section 1923(g) of the Act.

Response: The statute requires that the uncompensated care definition used in the UPF exclude bad debt. We have finalized the rule to rely on the uncompensated care cost data derived from Medicaid DSH audit and reporting data. Consistent with statutory direction, this uncompensated care data excludes bad debt, including unpaid copayments and deductibles, associated with individuals with a source of third party coverage for the service received during the year. Additionally, changes to calculating the hospital-specific DSH limit are outside the scope of the proposed rule. We issued policy on hospital-specific DSH limits through separate rulemaking. The regulation does not implement or otherwise address the calculation of hospital-

specific DSH payment limits under section 1923(g) of the Act.

Comment: One commenter recommended that we permit the use of average hospital cost-center specific ratios instead of cost center-specific cost-to-charge ratios in the definition of uncompensated care costs used for purposes of the UPF. Two commenters also recommended the inclusion of Graduate Medical Education (GME) costs in the uncompensated care cost definition.

Response: The Medicaid DSH audit and reporting rule data is the only data source available to us consistent with the statutory definition of uncompensated care cost for determining hospital-specific DSH limits. We are finalizing the reliance on this data in the UPF because it represents the best available data that is consistent with program definitions. Further, changes to calculating the hospital-specific DSH limit are outside the scope of the proposed rule.

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

The statute requires that we take into account the extent to which a state's DSH allotment was included in the budget neutrality calculation for a coverage expansion that was approved under section 1115 as of July 31, 2009. Prior to the implementation of this proposed rule, these states possess full annual DSH allotments as calculated under section 1923(f) of the Act. Under an approved section 1115 demonstration, however, the states may have limited authority to make DSH payments under section 1923 of the Act because all or a portion of their DSH allotment was included in the budget neutrality calculation for a coverage expansion under an approved section 1115 demonstration or to fund uncompensated care pools and/or safety net care pools. For applicable states, DSH payments under section 1923 of the Act are limited to the DSH allotment calculated under section 1923(f) of the Act less the allotment amount included in the budget neutrality calculation. If a state's entire DSH allotment is included in the budget neutrality calculation, it would have no available DSH funds with which to make DSH payments under section 1923 of the Act for the period of the demonstration.

Consistent with the statute, for states that include their DSH allotment in budget neutrality calculations for coverage expansion under an approved section 1115 demonstration as of July 31, 2009, we proposed to exclude from DSH allotment reduction, for the HMF and the HUF factors, the amount of DSH

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

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

The proposed DHRM took into account the extent to which the DSH allotment for a state was included in the budget neutrality calculation approved under section 1115 as of July 31, 2009 by excluding amounts diverted specifically for a coverage expansion and automatically assigning qualifying states an average reduction amount (based on the state group) for any DSH allotment diverted for non-coverage expansion purposes and any amounts diverted for coverage expansion if the section 1115 demonstration was or is approved after July 31, 2009. DSH allotment reductions relating to two DHRM factors (the HUF and the HMF) are determined based on how states target DSH payments to certain hospitals. Since states qualifying under the budget neutrality provision would have limited or no relevant data for these two factors, we would be unable to evaluate how they spent the portion of their DSH allotment that was diverted for non-coverage expansion.

Accordingly, we proposed to maintain the HUF and HMF formula for DSH payments for which qualifying states would have available data. Because we would not have DSH payment data for DSH allotment amounts diverted for non-coverage expansion, we proposed to assign average HUF and HMF reduction percentages for the portion of their DSH allotment that they were unable to use to target payments to disproportionate share hospitals.

Instead of assigning the average percentage reduction to non-qualifying amounts, we considered using various alternative percentages. Additionally, for qualifying allotment amounts diverted specifically for coverage expansion, we considered applying the BNF reduction exclusion to the UPF in addition to the HMF and HUF. We solicited comment regarding the use of different percentages for the reductions to non-qualifying diversion amounts and regarding alternative BNF methodologies that may prove preferable alternatives.

Through the Affordable Care Act, the statute provided states with other, non-DSH funds to finance coverage expansions, thus limiting the need for the diverted DSH under demonstrations. Accordingly, the group of states affected by this factor today may change at a later time, depending on how and whether their coverage continues to be financed as part of their demonstrations. In addition, based on changes in the health coverage landscape, we will reevaluate this policy in future rulemaking.

Comment: Some commenters requested clarification regarding how CMS will determine the amount of the DSH allotment included in the calculation of budget neutrality that will not be considered an amount included for coverage expansion.

Response: For states whose DSH allotment was included in the budget neutrality calculation for a coverage expansion that was approved under section 1115 as of July 31, 2009, we will determine the amount of the state's DSH allotment included in the budget neutrality calculation for coverage expansion for the specific fiscal year subject to reduction. This amount is not subject to reductions under the HMF and HUF calculations. The DSH allotment amount included in the budget neutrality calculation remaining after the identification of the amount for coverage expansion is the DSH allotment amount that will be considered not included for coverage expansion. We intend to publish a separate DHRM technical guide that provides information regarding the DHRM calculation, including the additional information regarding the BNF calculation.

Comment: One commenter recommended that CMS modify the BNF to include safety net care pool and uncompensated care pool amounts to be treated the same as coverage expansion initiatives. Another commenter expressed support for the exclusion of uncompensated care and safety net care

pools from consideration as coverage expansion for purposes of the BNF.

Response: The proposed and final DHRM takes into account the extent to which the DSH allotment for a state was included in the budget neutrality calculation approved under section 1115 of the Act as of July 31, 2009, by excluding from the HMF and HUF amounts diverted specifically for a coverage expansion. Uncompensated care pools and safety net care pools do not result in coverage expansion, so they are excluded from consideration as coverage expansion for purposes of this factor. Accordingly, we finalized this provision of the rule as proposed.

Comment: A few commenters recommended that CMS modify the BNF date of July 31, 2009, to July 31, 2010, or to include all approved demonstrations regardless of the approval date.

Response: The statute requires that we take into account the extent to which a state's DSH allotment was included in the budget neutrality calculation for a coverage expansion that was approved under section 1115 of the Act as of July 31, 2009, specifically. Subsequent to this date, the Affordable Care Act provided states with other, non-DSH funds for such coverage expansions, thus limiting the need for the diverted DSH under demonstrations. Therefore, we are finalizing the rule as proposed. Based on changes in the health coverage landscape, we will reevaluate this policy in future rulemaking.

Comment: A commenter asked that we ensure that the DHRM gives full consideration to the statutory direction regarding the BNF and does not unfairly penalize states for which their DSH allotment was included in the budget neutrality calculation for a coverage expansion that was approved under section 1115 of the Act as of July 31, 2009.

Response: We do not believe that the BNF unfairly penalizes qualifying states under this factor. The proposed and final DHRM takes into account the extent to which the DSH allotment for a state was included in the budget neutrality calculation approved under section 1115 of the Act as of July 31, 2009 by excluding from the HMF and HUF amounts diverted specifically for a coverage expansion and automatically assigning qualifying states an average HMF and HUF reduction amount (based on the state group) for any DSH allotment diverted for non-coverage expansion purposes and any amounts diverted for coverage expansion if the demonstration under section 1115 of the Act was or is approved after July 31, 2009.

IV. Provisions of the Final Regulations

The final rule is substantively the same as the method in the proposed rule, but includes some technical updates, corrections, and clarifications after reviewing the public comments as noted in section III of this final rule.

V. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. To fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

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

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

In our May 15, 2013 (78 FR 28551), proposed rule, we solicited public comment on each of the section 3506(c)(2)(A)-required issues for the following information collection requirements (ICRs). We received the following comment:

Comment: A commenter stated that the burden estimate of 4 hours to comply with the added DSH reporting requirements at § 447.299 is understated due to the amount of time required for the state to review the requirements, modify state rules, consult legal counsel, hold public hearings, and otherwise implement the new requirements.

Response: We disagree that the burden estimate associated with the added DSH reporting requirements should be increased and believe that our initial estimate is accurate. States are already required to submit an annual DSH audit and associated report to CMS. This rule simply adds three additional data elements (Medicaid provider number, Medicare provider

number, and total cost) to the existing reporting that should be easily accessible to states.

ICRs Regarding Reporting Requirements (§ 447.299)

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

The ongoing burden associated with the requirements under § 447.299 is the time and effort it would take each of the 50 state Medicaid Programs and the District of Columbia to complete the annual Medicaid DSH reporting requirements. Based on the information in this rule, we estimate that it will take an additional 4 hours per state (from 38 approved hours to 42 total hours) to complete the DSH reporting spreadsheets. Consequently, we also estimate an additional 204 (4 hr × 51 respondents) annual hours for all states and the District of Columbia and an additional aggregate cost of \$8,136.54 (51 × [\$51 × 2 hr] + [\$28.77 × 2 hr]).

In deriving these figures, we used the following hourly labor rates and estimated the time to complete each task: \$51 per hour and an additional 102 hours (204 hr × 0.5) for management and professional staff to review and prepare reports, and \$28.77 per hour and an additional 102 hours (204 hr × 0.5) for office staff to prepare the reports.

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

Submission of PRA-Related Comments

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

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

We invite public comments on this rule's information collection requirements. If you would like to

comment, please submit your comments to the Office of Information and Regulatory Affairs, Office of Management and Budget, Attention: CMS Desk Officer, (CMS-2367-F) Fax: (202) 395-6974; or Email: OIRA_submission@omb.eop.gov.

Comments must be received by October 18, 2013.

VI. Regulatory Impact Analysis

A. Statement of Need

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

B. Overall Impact

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

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). This rule has been designated an “economically significant” rule measured by the \$100 million threshold, under section 3(f)(1) of Executive Order 12866. Accordingly, we have prepared a Regulatory Impact Analysis (RIA) that, to the best of our ability, presents the costs and benefits of the rulemaking. In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of \$100 million in 1995 dollars, updated annually for inflation. In 2013, that threshold is approximately \$141 million. This final rule contains

reporting requirements on states which would be \$8,136.54 annually.

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

The RFA requires agencies to analyze options for regulatory relief of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of less than \$7.0 million to \$35.5 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. Since states are responsible in the management of the reduced allotments, we cannot predict the exact impact on individual hospitals. However, the aggregate estimated reduction of DSH allotment reductions at the state level is generally less than 6 percent of total Medicaid DSH allotment amounts. We estimate that the reduction in payments resulting from the DSH allotment reductions will account for significantly less than 3 to 5 percent of total hospital revenue. Therefore, we do not believe that this threshold will be reached by the requirements in this final rule.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area for Medicare payment regulations and has fewer than 100 beds. 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 are not preparing an analysis for section 1102(b) of the Act because we do not believe that this threshold will be reached by the requirements in this final rule.

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

C. Anticipated Effects

1. Effects on State Medicaid Programs

Effective for FY 2014, the DSH allotment reductions will have a direct effect on the ability for some or all states to maintain state-wide Medicaid DSH payments at FY 2013 levels. Federal share DSH allotments, which are published by CMS in an annual **Federal Register** notice, limit the amount of FFP in the aggregate that states can pay annually in DSH payments to hospitals. This final rule will reduce state DSH allotment amounts and therefore, will limit the states’ ability to make DSH payments and claim FFP for DSH payments at FY 2013 levels. By statute, the rule will reduce state DSH allotments by \$500,000,000 for FY 2014 and \$600,000,000 for FY 2015. The rule will reduce total FFP claimed by states by similar amounts, although it may not equal the exact amount of the allotment reductions. At this time, we cannot anticipate how states will change their existing DSH methodologies in response to the rule, and therefore cannot provide a specific estimate of the total federal financial impact for FY 2014 and FY 2015.

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

Additionally, the final rule requires additional annual DSH reporting requirements on states. For more information regarding the effects of these requirements on states, see section V. of this final rule.

2. Effects on Providers

The final rule will affect certain providers through the reduction of state DSH payments. However, we cannot estimate the impact on individual providers or groups of providers. This final rule will not affect the considerable flexibility afforded states in setting DSH state plan payment methodologies to the extent that these

methodologies are consistent with section 1923(c) of the Act and all other applicable statute and regulations. States will retain the ability to preserve existing DSH payment methodologies or to modify methodologies by submitting state plan amendments to us. Some states may determine that implementing a proportional reduction in DSH payments for all qualifying hospitals is the preferred method to account for the reduced allotment. Alternatively, states could determine that the best action is to propose a methodology that will direct DSH payments reductions to hospitals that do not have high Medicaid volume or do not have high levels of uncompensated care. Regardless, the rule incentivizes states to target DSH payments to hospitals that are most in need of Medicaid DSH funding based on their serving a high volume of Medicaid inpatients and having a high level of uncompensated care.

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

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

setting DSH payments to account for their reduced DSH allotment and how this would affect individual providers or specific groups of providers.

D. Alternatives Considered

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

E. Accounting Statement and Table

As required by OMB Circular A-4 (available at http://www.whitehouse.gov/omb/circulars_a004_a-4/), we have prepared an accounting statement in Table 1 showing the classification of the impacts associated with implementation of this final rule.

TABLE 1—ACCOUNTING STATEMENT

Category	Estimates	Units		
		Year dollar	Discount rate (percent)	Period covered
Costs:				
Cost of Reporting Requirement (in millions)	0.008	2013	7	2014–2015
	0.008	2013	3	2014–2015
Transfers:				
Reductions in Disproportionate Share Hospital Allotment (in millions)	– 548	2013	7	2014–2015
	– 549	2013	3	2014–2015
From Whom to Whom	Federal Government to the States on behalf of the Beneficiaries			

List of Subjects in 42 CFR Part 447

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

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

PART 447 —PAYMENTS FOR SERVICES

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

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

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

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

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

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

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

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

Budget neutrality factor (BNF) is a factor incorporated in the DHRM that takes into account the extent to which the DSH allotment for a State was included in the budget neutrality calculation for a coverage expansion approved under section 1115 as of July 31, 2009.

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

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

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

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

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

High volume of Medicaid inpatients factor (HMF) is a factor incorporated in

the DHRM that results in larger percentage DSH allotment reduction for States that do not target DSH payments on hospitals with high volumes of Medicaid inpatients.

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

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

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

Mean HUF reduction percentage is determined by calculating the quotient of each state's HUF reduction amount divided by its unreduced DSH allotment, then calculating the mean for each state group, then converting the result to a percentage.

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

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

State group means similarly situated States that are collectively identified by DHRM as defined in § 447.294(e)(1).

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

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

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

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

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

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

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

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

Uninsured population means 1-year estimates data of the number of

uninsured identified by United States Census Bureau's American Community Survey.

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

(d) *State data submission requirements.* States are required to submit the mean MIUR, determined in accordance with section 1923(b)(1)(A) of the Act, for all hospitals receiving Medicaid payments in the State and the value of one standard deviation above such mean. States must provide the data for State Plan Rate Year (SPRY) 2008, SPRY 2009, SPRY 2010, and SPRY 2011 by June 30, 2014. States must provide this data for each subsequent SPRY to CMS by June 30 of each year. To determine which SPRY's data the state must submit, subtract 3 years from the calendar year in which the data is due. For example, SPRY 2012 data must be submitted to CMS by June 30, 2015.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(iv) Adding the value of paragraph (e)(4)(iii) of this section to the value of paragraph (e)(2)(ii) of this section for the non-low DSH State group.

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

(i) UPF—33 and $\frac{1}{3}$ percent.

(ii) HMF—33 and $\frac{1}{3}$ percent.

(iii) HUF—33 and $\frac{1}{3}$ percent.

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

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

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

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

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

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

(7) *UPF application and reduction amount.* CMS will determine the UPF

portion of the final aggregate DSH allotment reduction allocation for each State by multiplying the State's UPF by the aggregate DSH allotment reduction allocated to the UPF factor under paragraph (e)(5) of this section for the respective State group.

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

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

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

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

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

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

(ii) Determining the amount of the State's DSH allotment included in the budget neutrality calculation for non-

coverage expansion purposes for the specific fiscal year subject to reduction.

(iii) Multiplying each qualifying State's value of paragraph (e)(12)(ii) of this section by the mean HMF reduction percentage for the respective State group.

(iv) Multiplying each qualifying State's value of paragraph (e)(12)(ii) of this section by the mean HUF reduction percentage for the respective State group.

(v) For each State, calculating the sum of the value of paragraphs (e)(12)(iii) and of (e)(12)(iv) of this section.

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

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

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

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

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

(f) *Annual DSH allotment reduction application.* For each fiscal year 2014 and fiscal year 2015, CMS will subtract the State-specific DSH allotment amount determined in paragraph (e)(14) of this section from that State's final unreduced DSH allotment. This amount is the State's final DSH allotment for the fiscal year.

- 3. Section 447.299 is amended by:
- A. Redesignating paragraph (c)(18) as (c)(21).
- B. Adding paragraphs (c)(18), (c)(19) and (c)(20).
- C. Revising newly redesignated paragraph (c)(21).

The additions and revisions read as follows:

§ 447.299 Reporting Requirements.

* * * * *

(c) * * *

(18) *Medicaid provider number.* The provider identification number assigned by the Medicaid program.

(19) *Medicare provider number.* The provider identification number assigned by the Medicare program.

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

(21) *Reporting.* States must report DSH payments made to all hospitals under the authority of the approved Medicaid State plan. This includes both in-State and out-of-State hospitals. For out-of-State hospitals, States must report, at a minimum, the information identified in § 447.299(c)(1) through (c)(6), (c)(8), (c)(9), (c)(17), (c)(18), and (c)(19).

* * * * *

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

Dated: August 29, 2013.

Marilyn Tavenner,

Administrator, Centers for Medicare & Medicaid Services.

Approved: September 9, 2013.

Kathleen Sebelius,

Secretary, Department of Health and Human Services.

[FR Doc. 2013-22686 Filed 9-13-13; 4:15 pm]

BILLING CODE 4120-01-P

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 622

[Docket No. 130627573-3796-02]

RIN 0648-BD39

Fisheries of the Caribbean, Gulf of Mexico, and South Atlantic; Reef Fish Fishery of the Gulf of Mexico; Red Snapper Management Measures

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Final rule.

SUMMARY: NMFS issues this final rule to implement management measures described in a framework action to the Fishery Management Plan for the Reef Fish Resources of the Gulf of Mexico (FMP), as prepared by the Gulf of Mexico Fishery Management Council (Council). This rule increases the 2013 commercial and recreational quotas for red snapper in the Gulf of Mexico (Gulf) reef fish fishery and re-opens the red snapper recreational season for 2013. This final rule is intended to allow increased harvest of Gulf red snapper without increasing the risk of red snapper experiencing overfishing or jeopardizing the rebuilding plan.