guide the Coast Guard in complying with the National Environmental Policy Act of 1969 (42 U.S.C. 4321–4370f), and have made a preliminary determination that this action is one of a category of actions that do not individually or cumulatively have a significant effect on the human environment. This proposed rule involves a safety zone lasting 6 hours, each day of the event, that would prohibit entry within a small portion of the Back River. Normally such actions are categorically excluded from further review under paragraph L60(a) of Appendix A, Table 1 of DHS Instruction Manual 023–01–001–01, Rev. 1. A preliminary Record of Environmental Consideration supporting this determination is available in the docket. For instructions on locating the docket, see the **ADDRESSES** section of this preamble. We seek any comments or information that may lead to the discovery of a significant environmental impact from this proposed rule.

G. Protest Activities

The Coast Guard respects the First Amendment rights of protesters. Protesters are asked to call or email the person listed in the **FOR FURTHER INFORMATION CONTACT** section to coordinate protest activities so that your message can be received without jeopardizing the safety or security of people, places, or vessels.

V. Public Participation and Request for Comments

We view public participation as essential to effective rulemaking and will consider all comments and material received during the comment period. Your comment can help shape the outcome of this rulemaking. If you submit a comment, please include the docket number for this rulemaking, indicate the specific section of this document to which each comment applies, and provide a reason for each suggestion or recommendation.

Submitting comments. We encourage you to submit comments through the Federal Decision-Making Portal at *https://www.regulations.gov.* To do so, go to *https://www.regulations.gov,* type USCG–2023–0112 in the search box and click ''Search.'' Next, look for this document in the Search Results column, and click on it. Then click on the Comment option. If you cannot submit your material by using *https://www.regulations.gov,* call or email the person in the **FOR FURTHER INFORMATION CONTACT** section of this proposed rule for alternate instructions.

Viewing material in docket. To view documents mentioned in this proposed rule as being available in the docket, find the docket as described in the previous paragraph, and then select ''Supporting & Related Material'' in the Document Type column. Public comments will also be placed in our online docket and can be viewed by following instructions on the *https://www.regulations.gov* Frequently Asked Questions web page. Also, if you click on the Dockets tab and then the proposed rule, you should see a ''Subscribe'' option for email alerts. The option will notify you when comments are posted, or a final rule is published.

We review all comments received, but we will only post comments that address the topic of the proposed rule. We may choose not to post off-topic, inappropriate, or duplicate comments that we receive.

Personal information. We accept anonymous comments. Comments we post to *https://www.regulations.gov* will include any personal information you have provided. For more about privacy and submissions to the docket in response to this document, see DHS's eRulemaking System of Records notice (85 FR 14226, March 11, 2020).

List of Subjects in 33 CFR Part 165

Harbors, Marine safety, Navigation (water), Reporting and recordkeeping requirements, Security measures, Waterways.

For the reasons stated in the preamble, the Coast Guard proposes to amend 33 CFR part 165, as follows:

PART 165—REGULATED NAVIGATION AREAS AND LIMITED ACCESS AREAS

■ 1. The authority citation for part 165 continues to read as follows:

Authority: 46 U.S.C. 70034, 70051, 70124; 33 CFR 1.05–1, 6.04–1, 6.04–6, and 160.5; Department of Homeland Security Delegation No. 00170.1, Revision No. 01.3.

■ 2. Add § 165.517 to read as follows:

§ 165.517 Safety Zone; Back River, Hampton, VA; Air Show

(a) *Location.* The following area is a safety zone: all navigable waters from the shoreline of the Back River contained within the following points: 37°5′34.32″ N, 076°20′47.13″ W; 37°5′38.05″ N, 076°20′36.49″ W; 37°5′30.53″ N, 076°20′31.86″ W.

(b) *Definitions.* As used in this section, *designated representative* means a Coast Guard Patrol Commander, including a Coast Guard coxswain, petty officer, or other officer operating a Coast Guard vessel and a Federal, State, and local officer designated by or assisting the Captain of the Port Virginia (COTP) in the enforcement of the safety zone.

(c) *Regulations.* (1) Under the general safety zone regulations in subpart C of this part, you may not enter the safety zone described in paragraph (a) of this section unless authorized by the COTP or the COTP's designated representative.

(2) To seek permission to enter, contact the COTP or the COTP's representative by VHF–FM Channel 16. Those in the safety zone must comply with all lawful orders or directions given to them by the COTP or the COTP's designated representative.

(d) *Enforcement period.* This section will be enforced annually on the third or fourth Friday through Sunday in April or the first or second Friday through Sunday in May from 10 a.m. to 4 p.m. each day during the event.

Dated: February 10, 2023.

J.A. Stockwell,

Captain, U.S. Coast Guard, Captain of the Port Virginia.

[FR Doc. 2023–03999 Filed 2–27–23; 8:45 am]

BILLING CODE 9110–04–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 412

[CMS–1788–P]

RIN 0938–AV17

Medicare Program; Medicare Disproportionate Share Hospital (DSH) Payments: Counting Certain Days Associated With Section 1115 Demonstrations in the Medicaid Fraction

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

ACTION: Proposed rule.

SUMMARY: This proposed rule would revise our regulations on the counting of days associated with individuals eligible for certain benefits provided by section 1115 demonstrations in the Medicaid fraction of a hospital's disproportionate patient percentage.

DATES: To be assured consideration, comments must be received at one of the addresses provided below by May 1, 2023.

ADDRESSES: In commenting, please refer to file code CMS–1788–P.

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

1. *Electronically.* You may submit electronic comments on this regulation

to *http://www.regulations.gov.* Follow the ''Submit a comment'' instructions.

2. *By regular mail.* You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1788–P, P.O. Box 8016, Baltimore, MD 21244–8016.

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

3. *By express or overnight mail.* You may send written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1788–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

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

FOR FURTHER INFORMATION CONTACT: Donald Thompson or Michele Hudson, *DAC@cms.hhs.gov,* (410) 786–4487.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following website as soon as possible after they have been received: *http://www.regulations.gov.* Follow the search instructions on that website to view public comments. CMS will not post on *Regulations.gov* public comments that make threats to individuals or institutions or suggest that the individual will take actions to harm the individual. CMS continues to encourage individuals not to submit duplicative comments. We will post acceptable comments from multiple unique commenters even if the content is identical or nearly identical to other comments.

I. Background

Section 1886(d)(5)(F) of the Social Security Act (the Act) provides for additional Medicare inpatient prospective payment system (IPPS) payments to subsection (d) hospitals [1] that serve a significantly disproportionate number of low-income patients. These payments are known as the Medicare disproportionate share hospital (DSH) adjustment, and the statute specifies two methods by which a hospital may qualify for the DSH payment adjustment.

- Under the first method, hospitals that are located in an urban area and have 100 or more beds may receive a DSH payment adjustment if the hospital can demonstrate that, during its cost reporting period, more than 30 percent of its net inpatient care revenues are derived from State and local government payments for care furnished to patients with low incomes. This method is commonly referred to as the ''Pickle method.''
- The second method for qualifying for the DSH payment adjustment, which is the most common method, is based on a complex statutory formula under which the DSH payment adjustment is based on the hospital's geographic designation, the number of beds in the hospital, and the level of the hospital's disproportionate patient percentage (DPP). A hospital's DPP is the sum of two fractions: the ''Medicare fraction'' and the ''Medicaid fraction.'' The Medicare fraction (also known as the ''SSI fraction'' or ''SSI ratio'') is computed by dividing the number of the hospital's inpatient days that are furnished to patients who were entitled to both Medicare Part A and Supplemental Security Income (SSI) benefits by the hospital's total number of patient days furnished to patients entitled to benefits under Medicare Part A. The Medicaid fraction is computed by dividing the hospital's number of inpatient days furnished to patients who, for such days, were eligible for Medicaid but were not entitled to benefits under Medicare Part A, by the hospital's total number of inpatient days in the same period.

Because the DSH payment adjustment is part of the IPPS, the statutory references to ''days'' in section 1886(d)(5)(F) of the Act have been interpreted to apply only to hospital acute care inpatient days. Regulations located at 42 CFR 412.106 govern the Medicare DSH payment adjustment and specify how the DPP is calculated as well as how beds and patient days are counted in determining the Medicare DSH payment adjustment. Under § 412.106(a)(1)(i), the number of beds for the Medicare DSH payment adjustment is determined in accordance with bed counting rules for the Indirect Medical Education (IME) adjustment under § 412.105(b). Section 1115(a) of the Act gives the Secretary the authority to approve a demonstration requested by a State which, ''in the judgment of the Secretary, is likely to assist in promoting the objectives of [Medicaid.]'' In approving a section 1115 demonstration, the Secretary may waive compliance with any Medicaid State plan requirement under section 1902 of the Act to the extent and for the period he finds necessary to enable the State to carry out such project. The costs of such project that would not otherwise be included as Medicaid expenditures eligible for Federal matching under section 1903 of the Act may, to the extent and for the period prescribed by the Secretary, be regarded as such federally matchable expenditures.

States use section 1115(a) demonstrations to test changes to their Medicaid programs that generally cannot be made using other Medicaid authorities, including to provide health insurance to groups that generally could not or have not been made ''eligible for medical assistance under a State plan approved under title XIX'' (Medicaid benefits). These groups, commonly referred to as expansion populations or expansion waiver groups, are specific, finite groups of people defined in the demonstration approval letter and special terms and conditions for each demonstration. (We note in the discussion that follows, we use the term ''demonstration'' rather than ''project'' and/or ''waiver'' and the term ''groups'' instead of ''populations,'' as this terminology is generally more consistent with the implementation of the provisions of section 1115 of the Act. Therefore, we refer in what follows to groups extended health insurance through a demonstration as ''demonstration expansion groups.'')

II. Provisions of the Proposed Regulation

A. History of 42 CFR 412.106(b)(4) and the Deficit Reduction Act of 2005

Prior to 2000, some States had chosen to only cover Medicaid populations under their State plans when State plan coverage was mandatory under the statute, and they did not provide State plan coverage for populations for whom the statute made State plan coverage optional. Instead, coverage for these optional State plan coverage groups (as well as groups not eligible for even optional coverage) could be provided through demonstrations approved under section 1115 of the Act. We referred to these demonstration groups that could have been covered under optional State plan coverage as ''hypothetical'' groups—consisting of patients that could have been but were not covered under a State plan, but that received the same or very similar package of insurance benefits under a demonstration as did individuals eligible for those benefits under the State plan. Many other States, however,

[1] Defined in section 1886(d)(1)(B) of the Act.

still elected to cover optional State plan coverage groups under their Medicaid State plans instead of through a demonstration. In order to avoid disadvantaging hospitals in States that covered such optional State plan coverage groups under a demonstration, CMS developed a policy of counting hypothetical group patients covered under a demonstration in the numerator of the Medicaid fraction of the Medicare DSH calculation (hereinafter, the DPP Medicaid fraction numerator) as if those patients were eligible for Medicaid.

Such demonstrations could also include individuals who could not have been covered under a State plan, such as childless adults for whom, at the time, State plan coverage was not mandatory under the statute, nor was optional State plan coverage available. We refer to these groups as ''expansion'' groups. Prior to 2000, CMS did not include expansion groups in the DPP Medicaid fraction numerator, even if they received the same package of hospital insurance benefits under a demonstration as hypothetical groups and those eligible under the State plan.

On January 20, 2000, we issued an interim final rule with comment period (65 FR 3136) (hereinafter, January 2000 interim final rule), followed by a final rule issued on August 1, 2000 (65 FR 47086 through 47087), that changed the Secretary's policy on how to treat the patient days of expansion groups that received Medicaid-like benefits under a section 1115 demonstration in calculating the Medicare DSH adjustment. The policy adopted in the January 2000 interim final rule (65 FR 3136) permitted hospitals to include in the DPP Medicaid fraction numerator all patient days of groups made eligible for title XIX matching payments through a section 1115 demonstration, whether or not those individuals were, or could be made, eligible for Medicaid under a State plan (assuming they were not also entitled to benefits under Medicare Part A). Speaking literally, neither expansion groups nor hypothetical groups were in fact ''eligible for medical assistance under a State plan''—meaning neither group was eligible for Medicaid benefits. But, in CMS' view, certain section 1115 demonstrations introduced an ambiguity into the DSH statute that justified including both hypothetical and expansion groups in the DPP Medicaid fraction numerator. Specifically, CMS thought it appropriate to count the days of these demonstration groups because the demonstrations provided them the same or very similar benefits as the benefits provided to Medicaid beneficiaries under the State plan. As we explained in that rule (65 FR 3137), allowing hospitals to include patient days for section 1115 demonstration expansion groups in the DPP Medicaid fraction numerator is fully consistent with the Congressional goals of the Medicare DSH payment adjustment to recognize the higher costs to hospitals of treating low-income individuals covered under Medicaid. This policy was effective for discharges occurring on or after January 20, 2000.

In the FY 2004 IPPS final rule (68 FR 45420 and 45421), we further revised our regulations to limit the types of section 1115 demonstrations for which patient days could be counted in the DPP Medicaid fraction numerator. We explained that in allowing hospitals to include patient days of section 1115 demonstration expansion groups, our intention was to include patient days of those groups who under a demonstration receive benefits, including inpatient hospital benefits, that are similar to the benefits provided to Medicaid beneficiaries under a State plan. However, we had become aware that certain section 1115 demonstrations provided some expansion groups with benefit packages so limited that the benefits were unlike the relatively expansive health insurance (including insurance for inpatient hospital services) provided to beneficiaries under a Medicaid State plan. We explained that these limited section 1115 demonstrations extend benefits only for specific services and do not include similarly expansive benefits.

In the FY 2004 IPPS final rule we specifically discussed family planning benefits offered through a section 1115 demonstration as an example of the kind of demonstration days that should not be counted in the DPP Medicaid fraction numerator because the benefits granted to the expansion group are too limited, and therefore, unlike the package of benefits received as Medicaid benefits under a State plan. Our intention in discussing family planning benefits under a section 1115 demonstration was not to single out family planning benefits, but instead to provide a concrete example of how the changes being made in the FY 2004 IPPS final rule would refine the Secretary's policy (set forth in the January 2000 interim final rule (65 FR 3136)). This refinement was to allow only the days of those demonstration expansion groups who are provided benefits, and specifically inpatient hospital benefits, equivalent to the health care insurance that Medicaid beneficiaries receive under a State plan, to be included in the DPP Medicaid fraction numerator. Moreover, this example was intended to illustrate the kind of benefits offered through a section 1115 demonstration that are so limited that the patients receiving them should not be considered eligible for Medicaid for purposes of the DSH calculation.

Because of the limited nature of the Medicaid benefits provided to expansion groups under some demonstrations, as compared to the benefits provided to the Medicaid population under a State plan, we determined it was appropriate to exclude the patient days of patients provided limited benefits under a section 1115 demonstration from the determination of Medicaid days for purposes of the DSH calculation. Therefore, in the FY 2004 IPPS final rule (68 FR 45420 and 45421), we revised the language of § 412.106(b)(4)(i) to provide that for purposes of determining the DPP Medicaid fraction numerator, a patient is deemed eligible for Medicaid on a given day only if the patient is eligible for inpatient hospital services under an approved State Medicaid plan or under a section 1115 demonstration. Thus, under our current regulations, hospitals are allowed to count patient days in the DPP Medicaid fraction numerator only if they are days of patients made eligible for inpatient hospital services under either a State Medicaid plan or a section 1115 demonstration, and who are not also entitled to benefits under Medicare Part A.

In 2005, the United States Court of Appeals for the Ninth Circuit held that demonstration expansion groups receive care ''under the State plan'' and that, accordingly, our pre-2000 practice of excluding them from the DPP Medicaid fraction numerator was contrary to the plain language of the Act. Subsequently, the United States District Court for the District of Columbia reached the same conclusion, reasoning that if our policy after 2000 of counting the days of demonstration expansion groups was correct, then patients in demonstration expansion groups were necessarily ''eligible for medical assistance under a State plan'' (that is, eligible for Medicaid), and the Act had always required including their days in the Medicaid fraction.

Shortly after these court decisions, in early 2006, Congress enacted the Deficit Reduction Act of 2005 (the DRA) (Pub. L. 109–171, February 8, 2006). Section 5002 of the DRA amended section 1886(d)(5)(F)(vi) of the Act to clarify the Secretary's discretion to regard as eligible for Medicaid those not so eligible and to include in or exclude from the DPP Medicaid fraction numerator demonstration days of

patients regarded as eligible for Medicaid. First, by distinguishing between ''patients *who . . . were eligible* for medical assistance under a State plan approved under subchapter XIX'' (that is, Medicaid) and ''*patients not so eligible* but who are regarded as such because they receive benefits under a demonstration project,'' section 5002(a) of the DRA clarified that groups that receive benefits through a section 1115 demonstration are not ''eligible for medical assistance under a State plan approved under title XIX.'' This provision effectively overruled the earlier court decisions that held that expansion groups were made eligible for Medicaid under a State plan. Second, the DRA stated ''the Secretary may, to the extent and for the period the Secretary determines appropriate, include patient days of patients not so eligible but who are regarded as such because they receive benefits under a demonstration project approved under title XI.'' Thus, the statute provides the Secretary the discretion to determine ''the extent'' to which patients ''not so eligible'' for Medicaid benefits ''may'' be ''regarded as'' eligible ''because they receive benefits under a demonstration project approved under title XI.'' Third, this same language provides the Secretary with further authority to determine the days of which patients regarded as being eligible for Medicaid to include in the DPP Medicaid fraction numerator and for how long.

Having provided the Secretary with the discretion to decide whether and to what extent to include patients who receive benefits under a demonstration project, Congress expressly ratified in section 5002(b) of the DRA our prior and then-current policies on counting demonstration days in the Medicaid fraction. As stated before, our pre-2000 policy was not to include in the DPP Medicaid fraction numerator days of section 1115 demonstration expansion groups unless those patients could have been made eligible for Medicaid under a State plan. We changed that policy in 2000 to include in the DPP Medicaid fraction numerator all patient days of demonstration expansion groups made eligible for matching payments under title XIX, regardless of whether they could have been made eligible for Medicaid under a State plan. And for FY 2004, before the DRA was enacted, CMS had further refined this policy and included in the DPP Medicaid fraction numerator the days of only a small subset of demonstration expansion group patients regarded as eligible for Medicaid: those that were eligible to receive inpatient hospital insurance benefits under the terms of a section 1115 demonstration. By ratifying the Secretary's pre-2000 policy, the January 2000 interim final rule, and the FY 2004 IPPS final rule, the DRA further established that the Secretary had always had the discretion to determine which demonstration expansion group patients to regard as eligible for Medicaid and whether or not to include any of them in the DPP Medicaid fraction numerator.

Because at the time the DRA was passed the language of § 412.106(b)(4) already addressed the treatment of section 1115 days to exclude some expansion populations that received limited health insurance benefits through the demonstration, we did not believe it was necessary to update our regulations after the DRA explicitly granted us the discretion to include or exclude section 1115 days from the Medicaid fraction of the DSH calculation. We believed instead the language of § 412.106(b)(4) reflected our view that only those eligible to receive inpatient hospital insurance benefits under a demonstration project could be ''regarded as'' ''eligible for medical assistance'' under Medicaid. Thus, considering this history and the text of the DRA, we understand the Secretary to have broad discretion to decide (1) whether and the extent to which to ''regard as'' eligible for Medicaid because they receive benefits under a demonstration those patients ''not so eligible'' under the State plan, and (2) of such patients regarded as Medicaid eligible, the days of which types of these patients to count in the DPP Medicaid fraction numerator and for what period of time to do so.

We do not believe that either the statute or the DRA permit or require the Secretary to count in the DPP Medicaid fraction numerator days of just any patient who is in any way related to a section 1115 demonstration. Rather, section 1886(d)(5)(F)(vi) of the Act limits including days of expansion group patients to those who may be ''regarded as'' ''eligible for medical assistance under a State plan approved under title XIX.''

B. Uncompensated/Undercompensated Care Funding Pools Authorized Through Section 1115 Demonstrations

CMS's overall policy for including section 1115 demonstration days in the DPP Medicaid fraction numerator rested on the presumption that the demonstration provided a package of health insurance benefits that were essentially the same as what a State provided to its Medicaid population. More recently, however, section 1115 demonstrations have been used to authorize funding a limited and narrowly circumscribed set of payments to hospitals. For example, some section 1115 demonstrations include funding for uncompensated/undercompensated care pools that help to offset hospitals' costs for treating uninsured and underinsured individuals. These pools do not extend health insurance to such individuals nor are they similar to the package of health insurance benefits provided to participants in a State's Medicaid program under the State plan. Rather, such funding pools ''promote the objectives of Medicaid'' as required under section 1115 of the Act, but they do so by providing funds directly to hospitals, rather than providing health insurance to patients. These pools help hospitals that treat the uninsured and underinsured stay financially viable so they can treat Medicaid patients.

By providing hospitals payment based on their uncompensated care costs, the pools directly benefit those providers, and, in turn, albeit less directly, the patients they serve. Unlike demonstrations that expand the group of people who receive health insurance beyond those groups eligible under the State plan and unlike Medicaid itself, however, uncompensated/undercompensated care pools do not provide inpatient health insurance to patients or, like insurance, make payments on behalf of specific, covered individuals.[2] In these ways, payments from these pools serve essentially the same function as Medicaid DSH payments under sections 1902(a)(13)(A)(iv) and 1923 of the Act, which are also title XIX payments to hospitals meant to subsidize the cost of treating the uninsured, underinsured, and low-income patients and that promote the hospitals' financial viability and ability to continue treating Medicaid patients. Notably, as numerous Federal courts across the country have universally held, the patients whose care costs are indirectly offset by such *Medicaid DSH* payments are not ''eligible for medical assistance'' under the *Medicare DSH* statute and are not included in the DPP Medicaid fraction numerator. See, for example, *Adena Regional Medical Center* v. *Leavitt*, 527 F.3d 176 (D.C. Cir. 2008); *Owensboro Health, Inc.* v. *HHS,* 832 F.3d 615 (6th Cir. 2016).

We also note that demonstrations can simultaneously authorize different programs within a single demonstration,

[2] For more information on this distinction, as upheld by courts, we refer readers to *Adena Regional Medical Center* v. *Leavitt,* 527 F.3d 176 (D.C. Cir. 2008), and *Owensboro Health, Inc.* v. *HHS,* 832 F.3d 615 (6th Cir. 2016).

thereby creating a group of people the Secretary regards as Medicaid eligible because they receive health insurance through the demonstration, while also creating a separate category of payments that do not provide health insurance to individuals, such as uncompensated/undercompensated care pools for providers.

C. Recent Court Decisions and Rulemaking Proposals on the Treatment of 1115 Days in the Medicare DSH Payment Adjustment Calculation

Several hospitals challenged our policy of excluding uncompensated/undercompensated care days and premium assistance days from the DPP Medicaid fraction numerator, which the courts have recently decided in a series of cases.[3] These decisions held that the current language of the regulation at § 412.106(b)(4) requires CMS to count in the DPP Medicaid fraction numerator patient days for which hospitals have received payment from an uncompensated/undercompensated care pool authorized by a section 1115 demonstration, as well as days of patients who received premium assistance under a section 1115 demonstration. Interpreting this regulatory language, that was adopted before the DRA was enacted, two courts concluded that if a hospital received payment for a patient's otherwise uncompensated inpatient hospital treatment, that patient is ''eligible for inpatient hospital services'' within the meaning of the current regulation, and therefore, his patient day must be included in the DPP Medicaid fraction. Likewise, a court concluded that patients who receive premium assistance to pay for private insurance that covers inpatient hospital services are ''eligible for inpatient hospital services'' within the meaning of the current regulation, and those patient days must be counted.

As discussed previously, it was never our intent when we adopted the current language of the regulation to include in the DPP Medicaid fraction numerator days of patients that benefitted so indirectly from a demonstration. In the FY 2022 IPPS/LTCH PPS proposed rule (86 FR 25459) (hereinafter, the FY 2022 proposed rule), we stated that we continued to believe, as we have consistently believed since at least 2000, that it is not appropriate to include patient days associated with funding pools and premium assistance authorized by section 1115 demonstrations in the DPP Medicaid fraction numerator because the benefits provided patients under such demonstrations are not similar to Medicaid benefits provided beneficiaries under a State plan and may offset costs that hospitals incur when treating uninsured and underinsured individuals. In the FY 2022 proposed rule, we proposed to revise our regulations to more clearly state that in order for an inpatient day to be counted in the DPP Medicaid fraction numerator, the section 1115 demonstration must provide inpatient hospital insurance benefits directly to the individual whose day is being considered for inclusion. We specifically discussed that, under the proposed change, days of patients who receive premium assistance through a section 1115 demonstration and the days of patients for which hospitals receive payments from an uncompensated/undercompensated care pool created by a section 1115 demonstration would not be included in the DPP Medicaid fraction numerator. Because neither premium assistance nor uncompensated/undercompensated care pools are inpatient hospital insurance benefits directly provided to individuals, nor are they comparable to the breadth of benefits available under a Medicaid State plan, we stated that individuals associated with such assistance and pools should not be ''regarded as'' ''eligible for medical assistance under a State plan.''

Commenters generally disagreed with our proposal, arguing that both premium assistance programs and uncompensated/undercompensated care pools are used to provide individuals with inpatient hospital services, either by reimbursing hospitals for the same services as the Medicaid program in the case of uncompensated/undercompensated care pools or by allowing individuals to purchase insurance with benefits similar to Medicaid benefits offered under a State plan in the case of premium assistance. Thus, they argued, those types of days should be included in the DPP Medicaid fraction numerator. Following review of these comments, in the final rule with comment period that appeared in the December 27, 2021 **Federal Register**, which finalized certain provisions of the FY 2022 proposed rule related to Medicare graduate medical education payments for teaching and Medicare organ acquisition payment, we stated that after further consideration of the issue we had determined not to move forward with our proposal and planned to revisit the issue of section 1115 demonstration days in future rulemaking (86 FR 73418).

After considering the comments we received in response to the FY 2022 proposed rule, in the FY 2023 IPPS/LTCH PPS proposed rule (87 FR 28398) (hereinafter, the FY 2023 proposed rule), we proposed to revise our regulation to explicitly reflect our interpretation of the language ''regarded as'' ''eligible for medical assistance under a State plan approved under title XIX'' in section 1886(d)(5)(F)(vi) of the Act to mean patients who (1) receive health insurance authorized by a section 1115 demonstration or (2) patients who pay for all or substantially all of the cost of health insurance with premium assistance authorized by a section 1115 demonstration, where State expenditures to provide the health insurance or premium assistance may be matched with funds from title XIX. Moreover, of the groups we regarded as Medicaid eligible, we proposed to use our discretion under the Act to include in the DPP Medicaid fraction numerator only (1) the days of those patients who obtained health insurance directly or with premium assistance that provides essential health benefits (EHB) as set forth in 42 CFR part 440, subpart C, for an Alternative Benefit Plan (ABP), and (2) for patients obtaining premium assistance, only the days of those patients for which the premium assistance is equal to or greater than 90 percent of the cost of the health insurance, provided in either case that the patient is not also entitled to Medicare Part A. (87 FR 28398 through 28402).

In the FY 2023 IPPS/LTCH PPS final rule (87 FR 49051), we noted that the agency received numerous, detailed comments on our proposal. We indicated that due to the number and nature of the comments that we received, and after further consideration of the issue, we had determined not to move forward with the FY 2023 proposal. We stated that we expected to revisit the treatment of section 1115 demonstration days for purposes of the DSH adjustment in future rulemaking (87 FR 49051).

D. Current Proposal To Amend 42 CFR 412.106(b)(4)

Consistent with our interpretation of the Medicare DSH statute over more than 2 decades and the history of our policy on counting section 1115 demonstration days in the DPP Medicaid fraction numerator set forth in our regulations, considering the series of adverse cases interpreting the current regulation, and in light of what we

[3] *Bethesda Health, Inc.* v. *Azar,* 980 F.3d 121 (D.C. Cir. 2020); *Forrest General Hospital* v. *Azar,* 926 F.3d 221 (5th Cir. 2019); *HealthAlliance Hospitals, Inc.* v. *Azar,* 346 F. Supp. 3d 43 (D.D.C. 2018).

proposed in the FY 2022 and FY 2023 proposed rules and our consideration of the comments we received thereon, we are again proposing to amend the regulation at § 412.106(b)(4). In order for days associated with section 1115 demonstrations to be counted in the DPP Medicaid fraction numerator, the statute requires those days to be of patients who can be ''regarded as'' eligible for Medicaid. Accordingly, and consistent with the proposed approach set forth in the FY 2023 proposed rule and with our longstanding interpretation of the statute and as amended by the DRA, and with the current language of § 412.106(b)(4), we are proposing to modify our regulations to explicitly state our long-held view that only patients who receive health insurance through a section 1115 demonstration where State expenditures to provide the insurance may be matched with funds from title XIX can be ''regarded as'' eligible for Medicaid.

Similar to our statements in the FY 2023 proposed rule, in further considering the comments regarding the treatment of the days of patients provided premium assistance through a section 1115 demonstration to buy health insurance, we are again proposing that such patients can also be regarded as eligible for Medicaid under section 1886(d)(5)(F)(vi) of the Act. Therefore, we propose for purposes of the Medicare DSH calculation in section 1886(d)(5)(F)(vi) of the Act to ''regard as'' ''eligible for medical assistance under a State plan approved under title XIX'' patients who (1) receive health insurance authorized by a section 1115 demonstration or (2) buy health insurance with premium assistance provided to them under a section 1115 demonstration, where State expenditures to provide the health insurance or premium assistance is matched with funds from title XIX. Furthermore, of these expansion groups we are proposing to regard as eligible for Medicaid, we propose to include in the DPP Medicaid fraction numerator only the days of those patients who receive from the demonstration (1) health insurance that covers inpatient hospital services or (2) premium assistance that covers 100 percent of the premium cost to the patient, which the patient uses to buy health insurance that covers inpatient hospital services, provided in either case that the patient is not also entitled to Medicare Part A. Finally, we propose stating specifically that patients whose inpatient hospital costs are paid for with funds from an uncompensated/undercompensated care pool authorized by a section 1115 demonstration are not patients ''regarded as'' eligible for Medicaid, and the days of such patients may not be included in the DPP Medicaid fraction numerator.

As discussed previously, we continue to believe it is not appropriate to include in the DPP Medicaid fraction numerator days of all patients who may benefit in some way from a section 1115 demonstration. First, we do not believe the statute permits everyone receiving a benefit from a section 1115 demonstration to be ''regarded as'' ''eligible for medical assistance under a State plan approved under title XIX'' merely because they receive a limited benefit. Second, even if the statute were so to permit, as discussed herein, the Secretary believes the DRA provides him with discretion to determine which patients ''not so eligible'' for Medicaid under a State plan may be ''regarded as'' eligible. Thus, the Secretary proposes to regard as Medicaid eligible only those patients who receive as ''benefits'' from a demonstration health insurance or premium assistance to buy health insurance, because—at root—''medical assistance under a State plan approved under title XIX'' provides Medicaid beneficiaries with health insurance, not simply medical care. Third, the DRA also gives the Secretary the authority to decide which days of patients ''regarded as'' Medicaid eligible to include in the DPP Medicaid fraction numerator. Using this discretion, we propose to include only the days of those patients who receive from a demonstration (1) health insurance that covers inpatient hospital services or (2) premium assistance that covers 100 percent of the premium cost to the patient, which the patient uses to buy health insurance that covers inpatient hospital services, provided in either case that the patient is not also entitled to Medicare Part A.

We note this is a change from the proposal included in the FY 2023 proposed rule, which would have required that the insurance provide EHB and the premium assistance cover at least 90 percent of the cost of the insurance. The feedback we received on that proposal from interested parties included concerns regarding, among other issues, the burden associated with verifying whether a particular insurance program in which an individual was enrolled provided EHB, how to determine whether a particular premium assistance program covered at least 90 percent of the cost of the insurance, and the difficulty in receiving accurate information on those issues in a timely manner. In light of this feedback, this proposal maintains the policy established in the regulations at least as far back as FY 2004 that days associated with individuals who obtain health insurance from a demonstration that covers inpatient hospital services be included in the DPP Medicaid fraction numerator. We do not believe that it would be unduly difficult for providers to verify that a particular insurance program includes inpatient benefits. (We refer readers to section III. of this proposed rule for more information on the burden estimate associated with this proposal.)

For those individuals who buy health insurance covering inpatient hospital services using premium assistance received from a demonstration, we are now proposing that the premium assistance cover 100 percent of the individual's cost of the premium. Indeed, it may be difficult to distinguish between patients who, on the one hand, receive through a demonstration health insurance for inpatient hospital services or 100 percent premium assistance to purchase health insurance and patients who, on the other hand, are eligible for medical assistance under the State plan: all patients receive health insurance paid for with title XIX funds, and all may be enrolled in a Medicaid managed care plan. We also do not believe that it will be difficult for providers to verify that a particular demonstration covers 100 percent of the premium cost to the patient, as it is our understanding that all premium assistance demonstrations currently meet that standard. In other words, as a practical matter, if a hospital is able to document that a patient is in a demonstration that explicitly provides premium assistance, then that documentation would also document that a patient is in a demonstration that covers 100 percent of the individual's costs of the premium. We also believe our proposed standard of 100 percent of the premium cost to the beneficiary is appropriate because it encapsulates all current demonstrations as a practical matter. If in the future there is a demonstration that explicitly provides premium assistance that does not cover 100 percent of the individual's costs for the premium, we may revisit this issue in future rulemaking.

As we have consistently stated, individuals eligible for medical assistance under title XIX are eligible for, among other things, specific benefits related to the provision of inpatient hospital services (in the form of inpatient hospital insurance). Because funding pool payments to hospitals authorized by a section 1115 demonstration do not provide health insurance to any patient, nor do the payments inure to any specific individual, uninsured patients whose costs are subsidized by uncompensated/

undercompensated care pool payments to hospitals do not receive benefits to the extent that or in a manner similar to the full equivalent of ''medical assistance'' available to those eligible under a Medicaid State plan. Uninsured or underinsured individuals, whether or not they benefit from uncompensated/undercompensated care pool payments to hospitals, do not have health insurance provided by the Medicaid program. Thus, we continue to believe that patients whose costs are associated with uncompensated/undercompensated care pools may not be ''regarded as'' Medicaid-eligible, and we are proposing to use the Secretary's discretion to not regard them as such. Even if they could be so regarded and irrespective of whether the Secretary has the discretion not to regard them as such, the Secretary also is proposing to use his authority to not include the days of such patients in the DPP Medicaid fraction numerator: Such patients have not obtained insurance under the demonstration, and including all uninsured patients associated with uncompensated/undercompensated care pools could distort the Medicaid proxy in the Medicare DSH calculation that is used to determine the low-income, non-senior population a hospital serves.[4] An uninsured patient who does not pay their hospital bill (thereby creating uncompensated care for the hospital) is not necessarily a low-income patient.

Accordingly, in this proposed rule, we are proposing to revise our regulations at § 412.106(b)(4) to explicitly reflect our interpretation of the language ''regarded as'' ''eligible for medical assistance under a State plan approved under title XIX'' ''because they receive benefits under a demonstration project approved under title XI'' in section 1886(d)(5)(F)(vi) of the Act to mean patients provided health insurance benefits by a section 1115 demonstration. Specifically, we are proposing to regard as Medicaid eligible for purposes of the Medicare DSH payment adjustment patients (1) who receive health insurance through a section 1115 demonstration itself or (2) who purchase health insurance with the use of premium assistance provided by a section 1115 demonstration, where State expenditures to provide the insurance or premium assistance is matchable with funds from title XIX. In addition, even if the statute would permit a broader reading, the Secretary is exercising his discretion under section 1886(d)(5)(F)(vi) of the Act to ''regard as'' Medicaid eligible only those patients. Furthermore, whether or not the Secretary has discretion to determine who is ''regarded as'' Medicaid eligible, we propose to use the authority provided the Secretary to limit the days of those section 1115 demonstration group patients included in the DPP Medicaid fraction numerator to only those of individuals who receive from the demonstration (1) health insurance that covers inpatient hospital services or (2) premium assistance that covers 100 percent of the premium cost to the patient, which the patient uses to buy health insurance that covers inpatient hospital services, provided in either case that the patient is not also entitled to Medicare Part A. Finally, we are proposing to explicitly exclude from the DPP Medicaid fraction numerator the days of patients with uncompensated care costs for which a hospital is paid from a funding pool authorized by a section 1115 demonstration project.

E. Responses to Relevant Comments to Recent Prior Proposed Rules

Many commenters on the FY 2022 and FY 2023 proposed rules asserted that the statute requires CMS to ''regard as'' Medicaid eligible patients with uncompensated care costs for which a hospital is paid from a demonstration funding pool and to count those patients' days in the DPP Medicaid fraction numerator. These commenters draw support for these conclusions by asserting that uninsured patients ''effectively'' receive insurance from an uncompensated/undercompensated care pool, and thus, cannot be reasonably distinguished from patients who receive insurance from the Medicaid program. They also stated that the inpatient benefits uninsured patients receive are the same inpatient benefits that Medicaid beneficiaries receive because the inpatient care they receive is the same.

We continue to disagree with the commenters' factual predicates and the legal conclusions that the statute requires a patient receiving any benefit from a section 1115 demonstration to be ''regarded as'' a patient eligible for medical assistance under a State plan authorized by title XIX and that all days of such patients must be counted in the DPP Medicaid fraction numerator.

First, we disagree with the proposition that uninsured patients whose costs may be partially paid to hospitals by uncompensated/undercompensated care pools effectively have insurance, and therefore, are indistinguishable from Medicaid beneficiaries and expansion group patients whose days the Secretary includes in the DPP Medicaid fraction numerator. Uninsured patients, unlike Medicaid patients or expansion group patients, do not have health insurance. It is quite clear insurance that includes coverage for inpatient hospital services is beneficial in ways that uncompensated/undercompensated care pools are not or could not possibly be to individual patients.[5] Medicaid and other forms of health insurance are not merely mechanisms of payment to providers for costs of patient care: Health insurance provides a reasonable expectation on the part of the insurance holder that they can seek treatment without the risk of financial ruin. Hospitals may bill uninsured patients for the full cost of their care and refer their medical debts to collection agencies when they are unable to pay, even if some of their medical treatment costs may be paid to the provider by an uncompensated/undercompensated care pool. Thus, it remains the case that uninsured patients may avoid treatment for fear of being unable to pay for it. For example, if two patients receive identical care from a hospital that accepts government-funded insurance, but one of them has insurance as a Medicaid beneficiary or receives insurance through a section 1115 demonstration and therefore is financially protected, while the other patient is uninsured and spends years struggling to pay their hospital bill—even if the hospital receives partial payment from a demonstration-authorized uncompensated/undercompensated care pool for that patient's treatment—the two patients have not received the same benefit from the government or one that could reasonably be ''regarded as'' comparable. This distinction between insured and uninsured patients is meaningful in this context, and we believe it is a sound basis on which to distinguish the treatment of patient days in the DSH calculation of uninsured patients who may in some way benefit from a section 1115 demonstration-authorized uncompensated/undercompensated care pool and the days of patients provided health insurance as a Medicaid beneficiary

[4] See, *Becerra* v. *Empire Health Foundation,* 142 S. Ct. 2354, 2358 (2022) (the Medicaid fraction counts the low-income, non-senior population).

[5] See Health Insurance Coverage and Health—What the Recent Evidence Tells Us (*https://www.nejm.org/doi/pdf/10.1056/nejmsb1706645*); Economic and Employment Effects of Medicaid Expansion Under ARP | Commonwealth Fund (*https://www.commonwealthfund.org/publications/issue-briefs/2021/may/economic-employment-effects-medicaid-expansion-under-arp*). To be clear, we mention these studies only in support of our assertion that having health insurance is fundamentally different than not having insurance.

under a State plan or through a demonstration.

Second, we also disagree with commenters who have stated that uninsured patients whose costs may be paid to hospitals by an uncompensated/undercompensated care pool receive the same benefits as patients eligible for Medicaid because the inpatient hospital care is likely the same for both groups. As stated above, within the meaning of section 1886(d)(5)(F)(vi) of the Act, the ''benefits'' provided to the individual by Medicaid and other forms of insurance a patient receives is the promise of a payment made on behalf of a specific patient to a provider of care for providing the care, not the care itself the hospital provides. Also, the provision of inpatient hospital services and payment for such services are two distinct issues, and simply because a hospital treats a patient presenting a need for medical care does not indicate anything about whether or how the hospital may be paid for providing that care. Thus, the similarity of care a patient receives is irrelevant to the question of whether the ''benefits'' provided ''because'' of a demonstration may be ''regarded as'' something akin to ''medical assistance under a State plan approved under title XIX.''

Therefore, we continue to disagree, as we have explained both here and in previous rulemakings, that the statute allows us to regard uninsured patients as eligible for Medicaid, just because they in some way benefit from an uncompensated/undercompensated care pool authorized by a demonstration. We understand the statute to provide that we may only include patients who are regarded as being eligible for Medicaid, such as the expansion groups at issue in the Portland Adventist and Cookeville cases [6] who received from the demonstrations health insurance benefits that were like the ''medical assistance'' received by patients ''under a State plan.'' The Medicaid program can—and does (through Medicaid DSH payments)—subsidize the treatment of low-income, uninsured patients without making those individuals eligible for ''medical assistance,'' as that phrase is used in the statute. See, for example, *Adena Regional Medical Center* v. *Leavitt,* 527 F.3d 176 (D.C. Cir. 2008); *Owensboro Health, Inc.* v. *HHS,* 832 F.3d 615 (6th Cir. 2016). Therefore, we disagree that patients whose costs may be partially offset by an uncompensated/undercompensated care fund receive ''medical assistance'' as that phrase is used in the Medicare DSH provision at section 1886(d)(5)(F)(vi) of the Act.

As we explained in the FY 2023 proposed rule (87 FR 28108 and 28400) and reiterate again above, we believe that the statutory phrase ''regarded as such'' refers to patients who are regarded as eligible for medical assistance under a State plan approved under title XIX, and therefore, should be understood to refer to patients who get insurance coverage paid for with Medicaid funds, just as if they were actually Medicaid-eligible. In other words, they are people who are treated by the Medicaid program as if they are eligible for Medicaid because of a demonstration approved under title XI, not merely because they are people who might receive from a demonstration a benefit that is not health insurance (such as treatment at a hospital).

While it is true that a few courts have interpreted the regulation that we are proposing to replace to require including in the DPP Medicaid fraction numerator days associated with uncompensated/undercompensated care because they read the regulation to treat such days as those of patients regarded as eligible for Medicaid, we disagree with those holdings. As noted previously, the current regulation was drafted prior to the enactment of section 5002 of the DRA, and therefore, does not directly interpret the language the DRA added to the Medicare statute. Section 5002(b) of the DRA ratified CMS' pre-2000 policy of not including expansion groups, like those in Portland Adventist and Cookeville, in the DPP Medicaid fraction numerator. The DRA also ratified CMS' January 2000 policy, which reversed the pre-2000 policy and included all expansion group days; and it similarly ratified CMS's FY 2004 policy that limited the type of expansion days included in the DPP Medicaid fraction numerator. Therefore, it cannot be that section 5002 of the DRA requires that *all* days of patients that receive any benefit from a demonstration must be included in the DPP Medicaid fraction numerator, as some commenters have suggested. Rather, the DRA provides the Secretary with discretion to determine whether populations that receive benefits under a section 1115 demonstration should be ''regarded as'' eligible for Medicaid, and likewise provides the Secretary further discretion to determine ''the extent'' to which the days of those groups may be included in the DPP Medicaid fraction numerator.

For all of the reasons discussed herein and previously, to the extent commenters read the Forrest General case (*Forrest General Hospital* v. *Azar*, 926 F.3d 221 (5th Cir. 2019)) as interpreting section 1886(d)(5)(F)(vi) of the Act to require that any patient who benefits from a demonstration is regarded as eligible for Medicaid and required to be included in the Medicaid fraction, we respectfully disagree with that reading. Rather, the better reading of Forrest General is that the court determined that any patient who is ''regarded as'' eligible for medical assistance under the regulation (which the court found uninsured patients to be under the current regulation) must be included in the Medicaid fraction. We also disagree with this conclusion, for the reasons already stated. Nevertheless, we are proposing the changes in this rule to clarify whom the Secretary regards as eligible for Medicaid because of benefits provided by a section 1115 demonstration, and which of those patient days the Secretary proposes to include in the DPP Medicaid fraction numerator.

In light of our prior rulemakings on this subject, and Congress' intervention in enacting section 5002 of the DRA, we believe the Secretary has, and has always had, the discretion to regard as eligible for Medicaid—or not—populations provided benefits through a demonstration, and to include or exclude those regarded as eligible, as he deems appropriate. First, the statute clearly uses discretionary language. It specifies that ''the Secretary may, to the extent and for the period the Secretary determines appropriate, include patient days of patients not so eligible but who are regarded as such because they receive benefits under a demonstration project approved under title XI.'' As the Supreme Court recently explained, ''may'' is quintessentially discretionary language. The Supreme Court has repeatedly emphasized that the use of ''may'' in a statute is intended to confer discretion rather than establish a requirement.[7] ''The use of the word 'may' . . . thus makes clear that . . . the Secretary 'has the authority, but not the duty.' '' *Lopez* v. *Davis*, 531 U.S. 230, 241 (2001). So while the DSH statute specifies the Secretary must count the days of patients ''eligible for medical assistance under a State plan approved under title XIX'' in the DPP Medicaid fraction numerator, the DRA provides that the Secretary may count the days of

[6] *Portland Adventist Med. Ctr.* v. *Thompson,* 399 F.3d 1091, 1096 (9th Cir. 2005); *Cookeville Reg'l Med. Ctr.* v. *Thompson,* 2005 U.S. Dist. LEXIS 33351, *18 (D.D.C. Oct. 28, 2005).

[7] See *Opati* v. *Republic of Sudan*, 140 S. Ct. 1601, 1609 (2020) (The Court has ''repeatedly observed'' that ''the word 'may' clearly connotes discretion.''). See also, for example, *Weyerhaeuser Co.* v. *United States Fish and Wildlife Serv.*, 139 S. Ct. 361, 371 (2018); *Jama* v. *Immigration and Customs Enforcement*, 543 U.S. 335, 346 (2005).

those ''not so eligible'' (that is, patients not eligible for Medicaid).

The additional clause ''to the extent and for the period the Secretary determines appropriate'' provides even more evidence that Congress sought to give the Secretary the authority to determine which ''patient days of patients not so eligible [for Medicaid] but who are regarded as such'' to count in the DPP Medicaid fraction numerator. In other words, the statute expressly contemplates that the Secretary may include the days of patients who are not actually eligible for medical assistance under a State plan approved under title XIX (eligible for Medicaid), but who are treated for all intents and purposes as if they were eligible for such ''medical assistance.'' But the Secretary is not commanded that he must count such patients. Accordingly, we disagree with commenters who stated that the statute requires we count in the DPP Medicaid fraction numerator all patients who benefit from a demonstration. Rather, the statute authorizes the Secretary to determine, as ''the Secretary determines [is] appropriate,'' whether patients are regarded as being eligible for Medicaid and, if so, ''the extent'' to which to include their days in the Medicaid fraction.

Furthermore, even if uninsured patients are regarded as eligible for Medicaid, we propose not including them in the DPP Medicaid fraction numerator for policy reasons. The DPP is intended to be a proxy calculation for the percentage of low income patients a hospital treats. Congress has defined the proxy to count in the Medicare fraction the days of patients entitled to Medicare Part A and SSI; the days of patients not entitled to Medicare but eligible for Medicaid are counted in the Medicaid fraction. Thus, not every low income patient is necessarily counted in the DPP proxy. If we counted all uninsured patients who could be said to have benefited from an uncompensated/undercompensated care pool (whether low income patients or not, because one need not be low-income to be uninsured and leave a hospital bill unpaid), we could potentially include in the DPP proxy not just all low-income patients in States with uncompensated/undercompensated care pools but also patients who are not low-income but who do not have insurance and did not pay their hospital bill. This would be a significant distortion from how Congress intended the DSH calculation to work, where the DPP is a proxy for the percentage of low-income patients hospitals serve based on patients covered by Medicare or Medicaid. We note that in contrast to an individual who could afford, but elects not to buy insurance, and lets bills go unpaid, an individual who receives insurance coverage under a section 1115 demonstration by definition must meet low income standards. By using our discretion to include in the DPP Medicaid fraction numerator only the days of those demonstration patients for which the demonstration provides health insurance that covers inpatient hospital care and the premium assistance that accounts for 100 percent of the premium cost to the patient, we believe we are hewing to Congress' intent to count some, but not necessarily all, low-income patients in the proxy.

Section 5002(b) of the DRA's ratification of the Secretary's prior policy and regulations on including or excluding demonstration group patient days from the DPP Medicaid numerator further supports our proposal here to exclude days of uninsured patients. By ratifying the Secretary's prior regulation that explicitly stated that our intent was to include in the fraction only the days of those that most looked like Medicaid-eligible patients, the limits we are proposing here to exclude days of uninsured patients whose costs are subsidized by uncompensated/undercompensated care pool funding fully align with Congress's amendment of the statute.

Also, counting all low-income patients in States with uncompensated/undercompensated care pools could drastically and unfairly increase DSH payments to hospitals located in States with broad uncompensated/undercompensated care pools in comparison to hospitals in States without uncompensated/undercompensated care pools, even though the cost burden on hospitals of treating low-income, uninsured patients might be higher in States without uncompensated/undercompensated care pools, precisely because they do not have uncompensated/undercompensated care pools. The purpose ''of the DSH provisions is not to pay hospitals the most money possible; it is instead to compensate hospitals for serving a disproportionate share of low-income patients.'' [8] We do not believe that purpose would be furthered by counting uninsured patients associated with uncompensated/undercompensated care pool funding as if they were patients eligible for Medicaid.

Thus, while we continue to believe that the statute does not permit patients who might indirectly benefit from uncompensated/undercompensated care pool funding to be ''regarded as'' eligible for Medicaid, if the statute permits us to regard such patients as eligible for medical assistance under title XIX, the statute also provides the Secretary with the discretion to determine whether to do so. We are electing to exercise the Secretary's discretion not to regard patients that may indirectly benefit from uncompensated/undercompensated funding pools as eligible for Medicaid. In any event, the statute also plainly provides the Secretary with the authority to determine whether to include patient days of patients regarded as eligible for Medicaid in the DPP Medicaid fraction numerator ''to the extent and for the period'' that the Secretary deems appropriate. Thus, we are also exercising the Secretary's discretion not to include in the DPP Medicaid fraction numerator patient days of patients associated with uncompensated/undercompensated care pool payments.

In summary, we are proposing to revise our regulations at § 412.106(b)(4) to explicitly reflect our interpretation of the language ''regarded as'' ''eligible for medical assistance under a State plan approved under title XIX'' ''because they receive benefits under a demonstration project approved under title XI'' in section 1886(d)(5)(F)(vi) of the Act to mean patients (1) who receive health insurance through a section 1115 demonstration itself or (2) who purchase health insurance with the use of premium assistance provided by a section 1115 demonstration, where State expenditures to provide the insurance or premium assistance may be matched with funds from title XIX. Alternatively, we are exercising the discretion the statute provides the Secretary to propose limiting to those two groups the patients the Secretary ''regard[s] as'' ''eligible for medical assistance under a State plan'' ''because they receive benefits under a demonstration.'' Moreover, using the Secretary's authority to determine the days of which demonstration groups ''regarded as'' Medicaid eligible to include in the DPP Medicaid fraction numerator, we propose that only the days of those patients who receive from the demonstration (1) health insurance that covers inpatient hospital services or (2) premium assistance that covers 100 percent of the premium cost to the patient, which the patient uses to buy health insurance that covers inpatient hospital services, are to be included, provided in either case that the patient is not also entitled to Medicare Part A.

[8] *Becerra* v. *Empire Health Found.*, 142 S. Ct. 2354, 2367 (2022) (emphasis added).

Finally, we are exercising the Secretary's discretion to not regard as Medicaid eligible patients whose costs are paid to hospitals from uncompensated/undercompensated care pool funds authorized by a section 1115 demonstration; and we are similarly exercising the Secretary's authority to exclude the days of such patients from being counted in the DPP Medicaid fraction numerator, even if those patients could be ''regarded as'' ''eligible for medical assistance under a State plan authorized by title XIX.'' Thus, we are also proposing to explicitly exclude from counting in the DPP Medicaid fraction numerator any days of patients for which hospitals are paid from demonstration-authorized uncompensated/undercompensated care pools.

In developing the proposal above, we considered counting the days of patients in the DPP Medicaid fraction numerator whose inpatient hospital costs are paid for with funds from an uncompensated/undercompensated care pool authorized by a section 1115 demonstration. However, after consideration, as discussed in greater detail above, because of the Secretary's interpretation of the statute and electing to exercise his discretion for policy reasons, we are not proposing to include counting patients whose inpatient hospital costs are paid for with funds from an uncompensated/undercompensated care pool authorized by a section 1115 demonstration in the DPP Medicaid fraction numerator. We invite public comments with regard to our statutory interpretation and our election to exercise the Secretary's authority discussed above, as well as our proposal not to count in the DPP Medicaid fraction numerator days of patients whose inpatient hospital costs are paid to hospitals from uncompensated/undercompensated care pool funds authorized by a section 1115 demonstration.

Finally, we propose that our revised regulation would be effective for discharges occurring on or after October 1, 2023. As has been our practice for more than two decades, we have made our periodic revisions to the counting of certain section 1115 patient days in the Medicare DSH calculation effective based on patient discharge dates. Doing so again here treats all providers similarly and does not impact providers differently depending on their cost reporting periods.

III. Collection of Information Requirements

A. Statutory Requirement for Solicitation of Comments

Under the Paperwork Reduction Act (PRA) 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 PRA 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.

In this proposed rule, we are soliciting public comment on the following information collection requirement (ICR).

B. ICR Relating To Counting Certain Days Associated With Section 1115 Demonstrations in the Medicaid Fraction

In the preamble of this proposed rule, we are proposing to revise the criteria for a hospital to count section 1115 demonstration inpatient days for which the patient is regarded as being eligible for Medicaid in the numerator of the Medicaid fraction: for the patient days of individuals who obtain benefits from a section 1115 demonstration, the demonstration must provide those patients with insurance that includes coverage of inpatient hospital services, or the insurance the patient purchased with premium assistance provided by the demonstration must include coverage of inpatient hospital service; and that for days of patients who have bought health insurance that provides inpatient hospital benefits using premium assistance obtained through a section 1115 demonstration, that assistance must be equal to 100 percent of the premium cost to the patient. We estimate 310 hospitals will be affected by this requirement, which is the total number of Medicare-certified subsection (d) hospitals in the seven States (Arkansas, Massachusetts, Oklahoma, Rhode Island, Tennessee, Utah, and Vermont) that currently operate approved premium assistance section 1115 demonstrations. The estimated total burden is $18,350,169 a year (1,736,883 inquiries a year × 0.25 hours per inquiry × (wages of $21.13/hour × 2 (fringe benefits)) = $18,350,169/year).

The number of inquiries is calculated by subtracting the total CY 2019 Medicare discharges from total CY 2019 discharges for all payers for all subsection (d) hospitals in each State with a currently approved premium assistance section 1115 demonstration. We used annualized discharges for both Medicare and all payer discharge figures rather than actual discharges, as some hospitals' cost reports do not provide data for an entire calendar year. To determine whether a patient's premiums for inpatient hospital services insurance are paid for by subsidies provided by a section 1115 demonstration, we believe hospitals would need to conduct inquiries for all patients with non-Medicare insurance for purposes of reporting on the Medicare cost report.[9] The estimated difference between all payer annualized discharges and annualized Medicare discharges was 1,736,883 in CY 2019.

We estimate that hospitals will use their existing communication methods that are in place to verify insurance information when collecting the information under this ICR. We estimate that verifying section 1115 demonstration waiver premium assistance status for private insurance for an individual will take 15 minutes. We believe that information clerks will be making these inquiries. Based on the most recent Bureau of Labor Statistics Occupational Employment Statistics data (May 2021) for Category 43–4199,[10] Information and Record Clerks, All Other, the mean hourly wage for an Information and Record Clerk is $21.13. We have added 100 percent for fringe and overhead benefits, which calculates to $42.26 per hour. We estimate the total annual cost is $18,350,159 (1,736,883 inquiries × 0.25 hours per inquiry × $42.26 per hour).

To obtain copies of a supporting statement and any related forms for the proposed collection summarized in this rulemaking document, please access the CMS PRA website by copying and pasting the following web address into your web browser and search the CMS–Form–2552–1: *https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing.*

If you wish to comment on this information collection with respect to reporting, recordkeeping, or third-party

[9] CMS–Form–2552–10 OMB No. 0938–0050.

[10] *https://www.bls.gov/oes/current/oes_nat.htm.*

disclosure requirements, please submit your comments electronically as specified in the **ADDRESSES** section of this proposed rule.

Comments must be received by May 1, 2023.

IV. Response to Comments

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

V. Regulatory Impact Analysis

A. Statement of Need

This proposed rule is necessary to make payment policy changes governing the treatment of certain days associated with section 1115 demonstrations in the DPP Medicaid fraction numerator for the purposes of determining Medicare DSH payments to subsection (d) hospitals under section 1886(d)(5)(F) of the Act. Specifically, we are proposing to revise our regulations to reflect explicitly our interpretation of the language ''patients . . . regarded as'' ''eligible for medical assistance under a State plan approved under title XIX'' ''because they receive benefits under a demonstration project approved under title XI'' in section 1886(d)(5)(F)(vi) of the Act to mean patients who receive health insurance through a section 1115 demonstration itself or who purchase insurance with the use of premium assistance provided by a section 1115 demonstration, where State expenditures to provide the insurance or premium assistance may be matched with funds from title XIX. Alternatively, the Secretary proposes to use his discretion under the statute to limit to these two groups those he regards as Medicaid eligible for the purpose of being counted in the DPP Medicaid fraction numerator. Moreover, of the groups ''regarded as'' Medicaid eligible, we propose that only the days of those patients who receive from the demonstration (1) health insurance that covers inpatient hospital services or (2) premium assistance that covers 100 percent of the premium cost to the patient, which the patient uses to buy health insurance that covers inpatient hospital services, be included, provided in either case that the patient is not also entitled to Medicare Part A. We are also proposing to revise our regulations to explicitly exclude days of patients for which hospitals are paid from uncompensated/undercompensated care pools authorized by section 1115 demonstrations for the cost of such patients' inpatient hospital services.

The primary objective of the IPPS is to create incentives for hospitals to operate efficiently and minimize unnecessary costs, while at the same time ensuring that payments are sufficient to adequately compensate hospitals for their legitimate costs in delivering necessary care to Medicare beneficiaries. In addition, we share national goals of preserving the Medicare Hospital Insurance Trust Fund.

We believe that the changes proposed in this rulemaking are needed to further each of these goals, while maintaining the financial viability of the hospital industry and ensuring access to high quality health care for Medicare beneficiaries. We expect that these proposed changes would ensure that the outcomes of the IPPS are reasonable and provide equitable payments, while avoiding or minimizing unintended adverse consequences.

B. Overall Impact

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

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). Section 3(f) of Executive Order 12866 defines a ''significant regulatory action'' as an action that is likely to result in a rule: (1) having an annual effect on the economy of $100 million or more in any 1 year, or adversely and materially affecting a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or tribal governments or communities (also referred to as ''economically significant''); (2) creating a serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raising novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in the Executive Order.

A regulatory impact analysis (RIA) must be prepared for major rules with significant regulatory action/s and/or with economically significant effects ($100 million or more in any 1 year). Based on our estimates, OMB's Office of Information and Regulatory Affairs has determined that this rulemaking is ''economically significant'' as measured by the $100 million threshold. Accordingly, we have prepared a Regulatory Impact Analysis that to the best of our ability presents the costs and benefits of the rulemaking. Therefore, OMB has reviewed this proposed regulation, and the Department has provided the following assessment of its impact.

C. Detailed Economic Analysis

1. Benefits

- Incentives for hospitals to operate efficiently and minimize unnecessary costs will be created, while at the same time ensuring that payments are sufficient to adequately compensate hospitals for their legitimate costs in delivering necessary care to Medicare beneficiaries;
- The Medicare Hospital Insurance Trust Fund will be preserved; and
- The financial viability of the hospital industry and access to high quality health care for Medicare beneficiaries will be maintained.

At this time, we are not able to quantify these benefits.

2. Costs

Reporting and recordkeeping costs incurred by the hospitals are presented in the Paperwork Reduction Act analysis, above. The costs of reviewing these regulations are discussed below.

3. Transfers

In section II. of this proposed rule, we discuss our proposed policies related to counting certain days associated with section 1115 demonstrations in the Medicaid fraction. Specifically, we are proposing to revise our regulations to explicitly reflect our interpretation of the language ''patients . . . regarded as'' ''eligible for medical assistance under a State plan approved under title XIX'' ''because they receive benefits under a demonstration project approved under

title XI'' in section 1886(d)(5)(F)(vi) of the Act to mean patients who receive health insurance authorized by a section 1115 demonstration or patients who pay for health insurance with premium assistance authorized by a section 1115 demonstration, where State expenditures to provide the health insurance or premium assistance may be matched with funds from title XIX. Alternatively, we are proposing to use the statutory discretion provided the Secretary to regard as eligible for Medicaid only these same groups of patients. Moreover, irrespective of which individuals are ''regarded as'' Medicaid eligible, the Secretary is exercising his discretion to include in the DPP Medicaid fraction numerator only the days of those patients who receive from the demonstration (1) health insurance that covers inpatient hospital services or (2) premium assistance that covers 100 percent of the premium cost to the patient, which the patient uses to buy health insurance that covers inpatient hospital services, provided in either case that the patient is not also entitled to Medicare Part A.

Seven States have section 1115 waivers that explicitly include premium assistance (we believe premium assistance in these States is 100 percent of the premium cost to the patients): Arkansas, Massachusetts, Oklahoma, Rhode Island, Tennessee, Utah, and Vermont. Hospitals in States that have section 1115 demonstration programs that explicitly include premium assistance (at 100 percent of the premium cost to the patient) would be allowed to continue to include these days in the numerator of the Medicaid fraction, provided the patient is not also entitled to Medicare Part A. Therefore, there would be no change to how these hospitals report Medicaid days and no impact on their Medicaid fraction as a result of our proposed revisions to the regulations regarding the counting of patient days associated with these section 1115 demonstrations.

For States that have section 1115 demonstrations that include uncompensated/undercompensated care pools, the patients whose care is subsidized by these section 1115 demonstration funding pools would not be ''regarded as'' ''eligible for medical assistance under a State plan approved under title XIX'' in section 1886(d)(5)(F)(vi) of the Act because the demonstration does not provide them with health insurance benefits. Even if they could be regarded as Medicaid eligible, the Secretary is proposing to use his authority to exclude the days of those patients from being counted in the DPP Medicaid fraction. Therefore, hospitals in the following six States would no longer be eligible to report days of patients for which they received payments from uncompensated/undercompensated care pools authorized by the States' section 1115 demonstration for use in the DPP Medicaid fraction numerator: Florida, Kansas, Massachusetts, New Mexico, Tennessee, and Texas.

To estimate the impact of the proposal to exclude uncompensated/undercompensated care pool days, we would need to know the number of these section 1115 demonstration days per hospital for the hospitals potentially impacted. We do not currently possess such data because the Medicare cost report does not include lines for section 1115 demonstration days separately from other types of days. Therefore, the number of demonstration-authorized uncompensated/undercompensated care pool days per hospital and the net overall savings of this proposal are especially challenging to estimate.

However, in light of public comments received in prior rulemakings recommending that we utilize plaintiff data in some manner to help inform this issue, we examined the unaudited figures claimed by plaintiffs in the most recent of the series of court cases on this issue, namely Bethesda Health, Inc. v. Azar, 980 F.3d 121 (D.C. Cir. 2020), as currently reflected in the System for Tracking Audit and Reimbursement (STAR or the STAR system) as of the time of this rulemaking. Of the Bethesda Health plaintiff data in the STAR system that listed reported section 1115 demonstration-approved uncompensated/undercompensated care pool days for purposes of effectuating the decision in that case, we utilized the reported unaudited amounts in controversy claimed by the plaintiffs for the more recent of their cost reports ending in FY 2016 or FY 2017. We then utilized the number of beds (2,490) reported in the March 2022 Provider Specific File to determine the average unaudited amount in controversy per bed ($2,477) for these plaintiffs. Based on the data as shown in Table 1, the average unaudited amount in controversy per bed for these plaintiffs is $2,477 (= $6,167,193/2,490). We note that there are *Bethesda Health* plaintiffs that do not have section 1115 demonstration program days listed in STAR, and one plaintiff that has section 1115 demonstration program days listed in STAR, but the most recent cost report with this data ends in FY 2012; therefore, these plaintiffs are not listed in Table 1.

TABLE 1—AVERAGE UNAUDITED AMOUNT IN CONTROVERSY PER BED (A/B)

Unaudited amount in controversy by plaintiff (A)	Beds (B)	Average unaudited amount in controversy per bed (A/B)
$2,174,897	382	
1,342,081	512	
253,404	210	
1,301,024	717	
505,899	310	
318,984	181	
270,905	178	
Total 6,167,193	Total 2,490	$2,477

In Table 2, we used the number of beds in DSH eligible hospitals in the six States with section 1115 demonstration programs that include uncompensated/undercompensated care pools to extrapolate the average unaudited amount in controversy per bed for the plaintiffs in Table 1 to all DSH eligible hospitals in those States. The resulting extrapolated unaudited amount in controversy is $348,749,215 (= 140,795 × $2,477).

TABLE 2—EXTRAPOLATED UNAUDITED AMOUNT IN CONTROVERSY

State	DSH hospital beds (A)	Unaudited average amount in controversy per bed from Table 1 (B)	Extrapolated unaudited amount in controversy (A × B)
Florida	50,352		
Kansas	5,881		
Massachusetts	13,099		

TABLE 2—EXTRAPOLATED UNAUDITED AMOUNT IN CONTROVERSY—Continued

State	DSH hospital beds (A)	Unaudited average amount in controversy per bed from Table 1 (B)	Extrapolated unaudited amount in controversy (A × B)
New Mexico	3,405	.....	.....
Tennessee	15,718	.....	.....
Texas	52,340	.....	.....
Total	140,795	$2,477	$348,749,215

Note, we caution against considering the extrapolated unaudited amount in controversy to be the estimated Trust Fund savings that would result from our proposal. For the reasons described earlier, the savings from our proposal are highly uncertain. The savings may be higher or lower than the extrapolated amount. However, we are providing the above transfer calculations in response to the public comments received on prior rulemaking on this issue, requesting that we utilize plaintiff data in some manner to help inform this issue.

D. Regulatory Review Cost Estimation

If regulations impose administrative costs on private entities, such as the time needed to read and interpret this proposed rule, we should estimate the cost associated with regulatory review. Due to the uncertainty involved with accurately quantifying the number of entities that will review the rule, we assume that the total number of IPPS hospitals, the majority of which are DSH eligible, will be the number of reviewers of this proposed rule. We acknowledge that this assumption may understate or overstate the costs of reviewing this rule. It is possible that not all IPPS hospitals will review this rule (such as those hospitals that consistently are not eligible for DSH payments), while certain hospital associations and other interested parties will likely review this rule. For these reasons, we believe that the total number of IPPS hospitals (3,150) would be a fair estimate of the number of reviewers of this rule. We welcome any comments on the approach in estimating the number of entities that will review this proposed rule.

Using the wage information from the BLS for medical and health service managers (Code 11–9111), we estimate that the cost of reviewing this rule is $115.22 per hour, including overhead and fringe benefits *https://www.bls.gov/oes/current/oes_nat.htm*. Assuming an average reading speed, we estimate that it would take approximately 1.5 hours for the staff to review this proposed rule. For each entity that reviews the rule, the estimated cost is $172.83 (1.5 hours × $115.22). Therefore, we estimate that the total cost of reviewing this regulation is $544,414.50 ($172.83 × 3,150 reviewers).

E. Alternatives Considered

This proposed rule would revise our regulations on counting days associated with individuals eligible for certain section 1115 demonstration programs in as hospital's DPP Medicaid fraction numerator. It also provides descriptions of the statutory provisions that are addressed, identifies the proposed policy, and presents rationales for our decisions and, where relevant, alternatives that were considered.

As discussed in section II. of this proposed rule, in the past we have received comments regarding the inclusion in the DPP Medicaid fraction numerator of the days of patients for which hospitals receive payments from an uncompensated/undercompensated care pool created by a section 1115 demonstration. We considered these comments for purposes of this rule. As we discussed in greater detail in section II. of this proposed rule, because uncompensated/undercompensated care pools are not inpatient hospital insurance benefits directly provided to individuals, nor are they comparable to the breadth of benefits available under a Medicaid State plan, we stated that the individuals whose costs may be subsidized by such pools should not be ''regarded as'' ''eligible for medical assistance under a State plan'' ''because they receive benefits under a demonstration project approved under title XI.'' Thus, while we continue to believe that the statute does not permit patients who might indirectly benefit from uncompensated/undercompensated care pool funding to be ''regarded as'' eligible for Medicaid, if the statute permits us to regard such patients as eligible for medical assistance under title XIX, the statute also provides the Secretary with ample discretion to determine whether to do so. As stated above, we are electing to exercise the Secretary's discretion not to regard patients that may indirectly benefit from uncompensated/undercompensated funding pools as so eligible. For a complete discussion, see section II. of this proposed rule.

F. Accounting Statement and Table

As required by OMB Circular A–4 (available at *https://obamawhitehouse.archives.gov/omb/circulars_a-004_a-4/* and *https://georgewbush-whitehouse.archives.gov/omb/circulars/a004/a-4.html*), we are required to prepare an accounting statement showing the classification of the expenditures associated with the provisions of this proposed rule as they relate to acute care hospitals. As discussed above, to estimate the impact of the proposal to exclude uncompensated/undercompensated care pool days from the DPP Medicaid fraction numerator, we would need to know the number of these days per hospital for the hospitals potentially impacted. We do not currently possess such data because the Medicare cost report does not include lines for section 1115 demonstration days separately from other types of days. Therefore, the number of demonstration-authorized uncompensated/undercompensated care pool days per hospital and the net overall savings of this proposal are highly uncertain. However, for purposes of the accounting statement in Table 3, we have included the extrapolated unaudited amount in controversy (from Table 2) as the net cost to IPPS Medicare Providers associated with the policy proposed in this proposed rule.

TABLE 3—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES FOR COUNTING CERTAIN DAYS ASSOCIATED WITH SECTION 1115 DEMONSTRATIONS IN THE MEDICAID FRACTION FOR MEDICARE DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENT

Category	Primary estimate	Low estimate	High estimate	Year dollar	Discount rate (%)	Period covered
Annualized monetized transfers to the Federal government from IPPS Medicare Providers	$349	$262	$436	2022	7	2022–2023
Annualized Monetized ($million/year)	0.54	0.41	0.68	2022	7	2022
Regulatory Review Costs	0.54	0.41	0.68	2022	3	2022

G. Regulatory Flexibility Act (RFA)

The RFA requires agencies to analyze options for regulatory relief of small entities if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, we estimate that almost all hospitals are small entities as that term is used in the RFA. The great majority of hospitals and most other health care providers and suppliers are small entities, either by being nonprofit organizations or by meeting the SBA definition of a small business (having revenues of less than $8.0 million to $41.5 million in any 1 year). (For details on the latest standards for health care providers, we refer readers to page 32 of the Table of Small Business Size Standards for Sector 62, Health Care and Social Assistance found on the SBA website at *http://www.sba.gov/content/small-business-size-standards*.)

Medicare Administrative contractors (MACs) are not considered to be small entities because they do not meet the SBA definition of a small business.

HHS's practice in interpreting the RFA is to consider effects economically ''significant'' if greater than 5 percent of providers reach a threshold of 3 to 5 percent or more of total revenue or total costs. We do not believe that the requirements in this proposed rule would reach this threshold. Specifically, based on data from the FY 2023 final rule, we estimate that DSH payments are approximately 2.8 percent of all payments under the IPPS for FY 2023. Therefore, the Secretary has certified that this proposed rule will not have a significant economic impact on a substantial number of small entities.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a proposed rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. For purposes of section 1102(b) of the Act, with the exception of hospitals located in certain New England counties, we define a small rural hospital as a hospital that is located outside of a metropolitan statistical area and has fewer than 100 beds. We are not preparing an analysis for section 1102(b) of the Act because we have determined, and the Secretary certifies, that this proposed rule would not have a significant impact on the operations of a substantial number of small rural hospitals.

H. Unfunded Mandates Reform Act (UMRA)

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending by State, local, and tribal governments in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2023, that threshold is approximately $177 million. This proposed rule does not mandate any requirements for State, local, or tribal governments, or for the private sector.

I. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. This proposed rule would not have a substantial direct effect on State or local governments, preempt States, or otherwise have a Federalism implication.

Chiquita Brooks-LaSure, Administrator of the Centers for Medicare & Medicaid Services, approved this document on January 10, 2023.

List of Subjects in 42 CFR Part 412

Administrative practice and procedure, Health facilities, Medicare, Puerto Rico, and Reporting and recordkeeping requirements.

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

PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

■ 1. The authority citation for part 412 continues to read as follows:

Authority: 42 U.S.C. 1302 and 1395hh.

■ 2. Amend § 412.106 by
■ a. Revising paragraphs (b)(4) introductory text, (i), and (ii);
■ b. Redesignating paragraphs (b)(4)(iii) and (iv) as paragraphs (b)(4)(iv) and (v), respectively; and
■ c. Adding new paragraph (b)(4)(iii).

The revisions and addition read as follows:

§ 412.106 Special treatment: Hospitals that serve a disproportionate share of low-income patients.

* * * * *

(b) * * *

(4) *Second computation.* The fiscal intermediary determines, for the same cost reporting period used for the first computation, the number of the hospital's patient days of service for patients (A) who were not entitled to Medicare Part A, and (B) who were either eligible for Medicaid on such days as described in paragraph (b)(4)(i) of this section or who were regarded as eligible for Medicaid on such days and the Secretary has determined to include those days in this computation as described in paragraph (b)(4)(ii)(A) or (B) of this section. The fiscal intermediary then divides that number by the total number of patient days in the same period. For purposes of this second computation, the following requirements apply:

(i) For purposes of this computation, a patient is eligible for Medicaid on a given day if the patient is eligible on that day for inpatient hospital services under a State Medicaid plan approved under title XIX of the Act, regardless of whether particular items or services were covered or paid for on that day under the State plan.

(ii) For purposes of this computation, a patient is regarded as eligible for Medicaid on a given day if (I) the patient receives health insurance

authorized by a demonstration approved by the Secretary under section 1115(a)(2) of the Act for that day, where the cost of such health insurance may be counted as expenditures under section 1903 of the Act, or (II) the patient has health insurance for that day purchased using premium assistance received through a demonstration approved by the Secretary under section 1115(a)(2) of the Act, where the cost of the premium assistance may be counted as expenditures under section 1903 of the Act, and in either case regardless of whether particular items or services were covered or paid for on that day by the health insurance. Of these patients regarded as eligible for Medicaid on a given day, only the days of patients meeting the following criteria on that day may be counted in this second computation:

(A) Patients who are provided by a demonstration authorized under section 1115(a)(2) of the Act health insurance that covers inpatient hospital services; or

(B) Patients who purchase health insurance that covers inpatient hospital services using premium assistance provided by a demonstration authorized under section 1115(a)(2) of the Act and the premium assistance accounts for 100 percent of the premium cost to the patient.

(iii) Patients whose health care costs, including inpatient hospital services costs, for a given day are claimed for payment by a provider from an uncompensated, undercompensated, or other type of funding pool authorized under section 1115(a) of the Act to fund providers' uncompensated care costs are not regarded as eligible for Medicaid for purposes of paragraph (b)(4)(ii) of this section on that day and the days of such patients may not be included in this second computation.

* * * * *

Dated: February 17, 2023.

Xavier Becerra,

Secretary, Department of Health and Human Services.

[FR Doc. 2023–03770 Filed 2–24–23; 4:15 pm]

BILLING CODE 4120–01–P

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 90

[WP Docket No. 07–100; FCC 23–3; FR ID 126041]

Improving Public Safety Communications in the 4.9 GHz Band

AGENCY: Federal Communications Commission.

ACTION: Proposed rule.

SUMMARY: In this document, the Federal Communications Commission (FCC) seeks comment on the details of implementing a new leasing model for the 4.9 GHz (4940–4990 MHz) band to achieve its goals of allowing robust locally controlled public safety operations while ensuring consistent, nationwide rules that promote overall spectral efficiency, foster innovation, and drive down equipment costs.

DATES: Interested parties may file comments on or before March 30, 2023; and reply comments on or before May 1, 2023.

ADDRESSES: Federal Communications Commission, 45 L St NE, Washington, DC 20554.

You may submit comments, identified by WP Docket No. 07–100, by any of the following methods:

- *Electronic Filers:* Comments may be filed electronically using the internet by accessing the ECFS: *http://apps.fcc.gov/ecfs/.*
- *Paper Filers:* Parties who choose to file by paper must file an original and one copy of each filing.
  - Filings can be sent by commercial overnight courier, or by first-class or overnight U.S. Postal Service mail. All filings must be addressed to the Commission's Secretary, Office of the Secretary, Federal Communications Commission.
  - Commercial overnight mail (other than U.S. Postal Service Express Mail and Priority Mail) must be sent to 9050 Junction Drive, Annapolis Junction, MD 20701. U.S. Postal Service first-class, Express, and Priority mail must be addressed to 45 L Street NE, Washington, DC 20554.
- Effective March 19, 2020, and until further notice, the Commission no longer accepts any hand or messenger delivered filings. This is a temporary measure taken to help protect the health and safety of individuals, and to mitigate the transmission of COVID–19. See FCC Announces Closure of FCC Headquarters Open Window and Change in Hand-Delivery Policy, Public Notice, DA 20–304 (March 19, 2020). *https://www.fcc.gov/document/fcc-closes-headquarters-open-window-and-changes-hand-delivery-policy* .

People with Disabilities: To request materials in accessible formats for people with disabilities (Braille, large print, electronic files, audio format), send an email to *fcc504@fcc.gov* or call the Consumer & Governmental Affairs Bureau at 202–418–0530 (voice), 202–418–0432 (TTY).

FOR FURTHER INFORMATION CONTACT: For additional information on this proceeding, contact Jon Markman of the Wireless Telecommunications Bureau, Mobility Division, at (202) 418–7090 or *Jonathan.Markman@fcc.gov* or Brian Marenco of the Public Safety and Homeland Security Bureau at (202) 418–0838 or *Brian.Marenco@fcc.gov.*

SUPPLEMENTARY INFORMATION: This is a summary of Commission's Ninth Further Notice in WP Docket No. 07–100; FCC 23–3, adopted and released on January 18, 2023. The full text of this document is available for public inspection online at *https://docs.fcc.gov/public/attachments/FCC-23-3A1.pdf.*

1. In this Ninth Further Notice, the Commission seeks comment on a range of questions related to the implementation of its new Band Manager model for the 4.9 GHz band adopted in the Seventh Report and Order. This model will preserve the essentially public safety nature of the band while decreasing access costs and expanding use to a variety of primary public safety and secondary non-public safety operations.

2. First, it seeks comment on the Band Manager's efforts in coordinating public safety operations, in particular mitigating harmful interference and modernizing operations. Next, it seeks comment on the Band Manager's role in facilitating leasing to non-public safety users; how to enable such leasing, how to manage the revenues that arise from it, and how to ensure preemption rights for public safety operations. It also seeks comment on the implementation of our committee-based selection process for the Band Manager, which mirrors the approach the Commission has taken for selecting clearinghouses and transition coordinators in a number of other bands. Finally, it seeks comment on oversight of the Band Manager and on other issues related to the implementation of the Band Manager model.

3. In particular, the Commission in this Ninth Further Notice builds off the record before it and seeks comment on specific criteria for protecting public safety licensees operating in the band from what it terms ''harmful