**Medicaid Program; Disproportionate Share Hospital Third-Party Payer Rule**
**[CMS-2445-P]**
**Summary of Proposed Rule**

On February 24, 2023, the Centers for Medicare & Medicaid Services (CMS) published a proposed rule in the Federal Register (88 FR 11865) that would address legislative changes to the hospital-specific limit on Medicaid disproportionate share hospital (DSH) payments that took effect on October 1, 2021, as a result of the Consolidated Appropriations Act (CAA), 2021. The proposed rule is intended to provide more clarity on how the limit will be calculated; it would also make technical changes and clarifications to the DSH program that CMS believes would enhance administrative efficiency.

**The 60-day comment period ends at the close of business on April 25, 2023.**

**Table of Contents**

## I. Background

### A. Overview

The Medicaid program provides funds to states to provide medical assistance to eligible individuals as specified in Title XIX of the Social Security Act (SSA) and subject to terms and conditions under statute and regulation. The Medicaid statute requires states to take into account, in establishing payment rates to hospitals, the situation of hospitals that serve a disproportionate share of low-income patients.

The proposed rule would update DSH regulatory requirements to reflect changes made by the CAA, 2021, concerning the treatment of third-party payments when calculating Medicaid hospital-specific DSH limits. CMS would also make changes to (i) clarify regulatory payment and financing definitions and other regulatory language that it believes may be subject to misinterpretation, (ii) refine administrative procedures used by states to comply with federal regulations, and (iii) remove regulatory requirements that it says have been difficult to administer and do not further the program's objectives.

The proposals that carry out changes occasioned by CAA, 2021, would apply retroactively as of October 1, 2021, which is consistent with the statute. Other provisions would take effect 60 days after the date of publication of the final rule.

### B. Disproportionate Share Hospital (DSH) Payments

#### 1. Background

Medicaid DSH payments are separate from base or supplemental payments, originating from a separate statutory authority[1] with a separate purpose. DSH payments are subject to certain limits and specific requirements. For example, states are provided with an annual allotment that they may not exceed,[2] and there are hospital-specific limits on DSH payments as well.[3]

#### 2. CAA, 2021 Requirements

Effective October 1, 2021, section 203 of the CAA, 2021, modified the calculation of the Medicaid portion of the hospital-specific DSH limit to include only costs and payments for services furnished to beneficiaries for whom Medicaid is the primary payer for those services.[4] Thus, the hospital-specific DSH limit excludes costs and payments for services furnished to Medicaid beneficiaries with other sources of coverage, such as Medicare and commercial insurance. However, section 203 provided an exception to this rule for those hospitals in the 97th percentile of all hospitals nationwide with respect to inpatient days made up of patients who, for

[1] Section 1923(d) of the SSA (42 U.S.C. 1396r-4(d)).
[2] Section 1923(f) of the SSA (42 U.S.C. 1396r-4(f)).
[3] Section 1923(g) of the SSA (42 U.S.C. 1396r-4(g)).
[4] Section 1923(g)(1)(B)(i) of the SSA (42 U.S.C. 1396r-4(g)(1)(B)(i)).

such days, were entitled to Medicare Part A benefits and to supplemental security income (SSI) benefits.[5]

The exception applies to hospitals that are in the 97th percentile, either with respect to the number of inpatient days or the percentage of total inpatient days that were made up of such days. The hospital-specific limit for a DSH hospital that qualifies for the exception is equal to the higher of (i) the limit as calculated under the methodology in effect before enactment of the CAA, 2021 (i.e., as in effect on January 1, 2020 and which counts payments made by third party payers)[6] or (ii) the limit as calculated under the methodology imposed by the CAA, 2021 (which counts payments only for beneficiaries for whom Medicaid is the primary payer). CMS says that data limitations have hampered its ability to determine which hospitals qualify for the exception; the proposed rule would specify how CMS will make these determinations.

3. Annual DSH Audits and Overpayments

Pursuant to the 2008 DSH audit final rule,[7] states must submit an annual report identifying Medicaid DSH payments to providers and must also submit an independently certified audit of the state's DSH program annually. A state must submit 18 data elements to CMS, at the same time as the state submits the completed audit so CMS can verify the appropriateness of those payments. One of those data elements is the total uncompensated care cost, which equals the total cost of care for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individuals and to individuals with no source of third-party coverage for the hospital services they receive, less the sum of other payment sources listed in 42 CFR 447.299(c)(16).

CMS raises the concern that, even though the audits and annual reports provide a great deal of information, it does not have the information it needs to determine if an overpayment has occurred and why. As a result, CMS is unable to ensure proper recovery of any federal share of DSH overpayments. CMS identifies reports from the Inspector General of the Department of Health and Human Services (HHS) as well as the Government Accountability Office (GAO) raising similar concerns with such overpayments. In lieu of conducting secondary reviews or audits, CMS proposes to require states to include an additional data element that provides a dollar estimate of any Medicaid DSH provider overpayments as part of the submission of state annual reports under 42 CFR 447.299(c).

Under current law and regulations, when an overpayment by a state is discovered, the state has a one-year period to recover or attempt to recover the overpayment before an adjustment is made to federal payments to the state to account for the overpayment. The one-year period begins on the date of discovery of the overpayment. While the regulations in 42 CFR 433.316 establish how the date of discovery of an overpayment is determined, it does not specify how this relates to the independent certified DSH audits. The 2008 DSH audit final rule addressed the return or redistribution of provider overpayments identified through DSH audits, but it did not include

[5] Section 1923(g)(2)(B) of the SSA (42 U.S.C. 1396r-4(g)(2)(B)).
[6] "DSH Payments—Treatment of Third-Party Payers in Calculating Uncompensated Care Costs" final rule in the April 3, 2017 Federal Register (82 FR 16114).
[7] "Medicaid Program; Disproportionate Share Hospital Payments" (73 FR 77904; December 19, 2008).

specific procedural requirements for returning or redistributing overpayments. CMS proposes changes to address this issue.

4. DSH Health Reform Reduction Methodology

As amended by the Affordable Care Act (ACA), section 1923(f)(7) of the SSA requires CMS to develop a methodology to determine annual, state-by-state DSH allotment reduction amounts to account for the anticipated decrease in uncompensated care as a result of expansions of coverage authorized by the ACA. CMS refers to this as the DSH Health Reform Reduction Methodology (DHRM), which is based on five factors: uninsured factor (UPF); Medicaid volume factor (HMF); uncompensated care factor (HUF); low DSH state factor (LDF); and the budget neutrality factor (BNF).

The five factors are specified in section 1923(f)(7)(B) of the SSA as follows:

- UPF: States with lower uninsurance rates receive higher percentage DSH reductions. Calculations for this factor use Census Bureau data that is subject to a 1-year lag.
- HMF: States that target DSH payments to hospitals with high Medicaid volume receive a lower percentage reduction in their DSH allotment. Calculations for this factor use DSH audit data that is on a 3-year lag.
- HUF: States that target DSH payments to hospitals with high levels of uncompensated care receive a lower percentage reduction in their DSH allotment. Calculations for this factor use DSH audit data that is on a 3-year lag.
- Low DSH state factor: "Low DSH states"[8] receive a lower overall DSH reduction percentage than non-low DSH states. Thus, low DSH states and non-low DSH states are separated into two cohorts before applying the reduction methodology.
- BNF: DSH allotment amounts diverted for coverage expansions under section 1115 demonstrations approved as of July 31, 2009, receive a limited protection from reduction.

However, Congress has regularly delayed the start of those reductions; the latest delay under the CAA, 2021 means that reductions are slated to occur during fiscal years (FY) 2024 through 2027, at a rate of $8 billion per fiscal year.

CMS had twice finalized methodologies in 42 CFR §447.294 to implement these reductions—one in 2013 and a revised methodology in 2019. The 2019 final rule[9] assigned weights to the annual reduction amount for the three core factors: UPF, HMF, and HUF. The remaining two factors, the LDF and the BNF, affect the allocation of the reduction amounts within the three core factors. Under this methodology, the LDF allocation is done at the front end of the calculations by shifting a portion of the reduction amount specified under section 1923(f)(7)(A)(ii) of the Act to non-low DSH states. After this step, CMS determines the reduction calculations prescribed by the three core factors. It then performs additional reductions associated with the BNF within the HMF and HUF for states that divert DSH allotment amounts under section 1115 demonstrations. CMS then reallocates these reduction amounts away from states that do not divert DSH allotment amounts under section 1115 demonstrations, to comply

[8] Section 1923(f)(5) of the SSA (42 U.S.C. 1396r-4(f)(5)).
[9] Medicaid Program; State Disproportionate Share Hospital Allotment Reductions (84 FR 50308; September 25, 2019).

with the aggregate reduction amounts specified under statute at section 1923(f)(7)(A)(ii) of the SSA.

5. Modernizing the Publication of Annual DSH and CHIP Allotments

CMS publishes preliminary annual DSH allotments and national expenditure targets in the Federal Register by October 1 of each FY and publishes the final allotments and national expenditure targets by April 1 of that FFY. CMS finds the current regulatory process to be cumbersome and unnecessary in light of more timely notification practices currently in place. The same applies for state CHIP allotment notices. It proposes to codify its more efficient practices and eliminate duplicative publication requirements.

**II. Provisions of the Proposed Rule**

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

Under current law and regulations, when an overpayment by a state is discovered, the state has a one-year period to recover or attempt to recover the overpayment before an adjustment is made to federal payments to the state to account for the overpayment. The one-year period begins on the date of discovery of the overpayment. Current regulations describe the date of discovery for certain overpayments, but do not describe what is meant by the date of discovery for overpayment of DSH payments. To address this, CMS proposes to amend §433.316 to add new paragraph (f) to specify that the date of discovery of overpayments identified through a DSH audit is the earliest of the following dates:

- The date on which the state submits the certified audit report under §455.304(b); or
- Any of the dates specified in existing §433.316(c)(1), (2), or (3), which would be:
    - (c)(1) The date on which a Medicaid official first notifies a provider in writing of an overpayment and specifies a dollar amount subject to recovery;
    - (c)(2) The date on which a provider initially acknowledges a specific overpaid amount in writing to the Medicaid agency; or
    - (c)(3) The date on which any state official initiates a formal action to recoup a specific overpaid amount from a provider without having first notified the provider in writing.

2. DSH Health Reform Reduction Methodology (§447.294)

The DSH Health Reform Reduction Methodology (DHRM) must consider the extent to which the DSH allotment for a state was included in the budget neutrality calculation for a coverage expansion approved under section 1115 of the SSA (i.e., a section 1115 demonstration to provide coverage to individuals not otherwise eligible for Medicaid) as of July 31, 2009. Under the 2019 final rule, the methodology excludes from DSH allotment reductions the amount of DSH allotment states had approved as of July 31, 2009 under a coverage expansion section 1115 demonstration. Any DSH allotment amounts included in budget neutrality calculations for non-coverage expansion purposes under approved 1115 demonstrations are still subject to reduction regardless of when they were approved.

Further, the preamble to the 2019 final rule indicates that for any section 1115 demonstrations not approved as of July 31, 2009, these DSH allotment amounts included in budget neutrality calculations, whether for coverage expansion or otherwise, would also be subject to reduction. CMS notes that all section 1115 demonstrations approved as of or before July 31, 2009, have expired and the protection does not apply to renewals or extensions of those 1115 demonstrations. Thus, CMS states that there no longer exist any amounts related to coverage expansion for exclusion from future DSH allotment reductions scheduled to begin in FY 2024.

CMS does not have DSH audit data relating to how states expend DSH allotment amounts diverted under section 1115 demonstrations; thus, it proposes to assign average HUF and HMF reduction percentages to these amounts. Further, it proposes to update the regulations at §447.294(e)(12) to clearly specify that amounts diverted under a section 1115 demonstration approved after July 31, 2009, are subject to average reductions under the HUF and HMF; this is described as essentially a codification of the policy finalized in the preamble to the 2019 final rule.

CMS proposes that the determination of diverted amounts that are subject to average reductions under the HUF and HMF would align with the state plan rate year (SPRY) for the DSH audits used in the DSH allotment reduction calculations[10] rather than the fiscal year subject to reduction. Thus, when it calculates the DSH allotment reductions for FY 2024, it would use data for each state's SPRY 2019 DSH audit data as it is the most recent data available to the agency. If a state did not divert its entire DSH allotment, CMS would include the amount of the state's DSH allotment diverted under a section 1115 demonstration for the time period that aligns with the associated SPRY (i.e., SPRY 2019 in the example in the preceding sentence). Each such state would then be assigned the average HUF and HMF reduction amounts for the state's respective state group based on this diverted amount.

CMS also proposes to remove the language "for the specific fiscal year subject to reduction" in paragraphs (e)(12) introductory text and (e)(12)(i) of §447.294 because it believes the current regulatory language could lead to anomalous results. The language results in a non-alignment between the SPRY 2019 DSH audit data that CMS would use to determine the HUF and HMF and the FY 2024 section 1115 demonstration budget neutrality calculation diversion amount that would be used under the current regulation; it notes that this could result in inappropriate and illogical outcomes. It believes its proposal to assign average HUF and HMF reduction percentages to diverted amounts in the absence of DSH audit data relating to how states expend DSH allotment amounts diverted under section 1115 demonstrations is reasonable. CMS concludes that it is appropriate that the amounts diverted under section 1115 demonstrations should align with the SPRY of the DSH audit used in the DHRM and that the amounts subject to reduction do not exceed what states could have expended, either through DSH payments or diverted DSH allotment amounts, during the associated SPRY.

The agency also proposes to state in paragraph (e)(12)(ii) of §447.294 that the budget neutrality calculations are performed on the amount of each state's DSH allotment diverted under an approved 1115 demonstration during the period that aligns with the associated SPRY DSH audit utilized in the DSH allotment reductions.

[10] See 42 CFR 447.294(d).

If a state diverts its entire DSH allotment and thus does not complete a DSH audit, CMS cannot use a DSH audit SPRY. To address this, it proposes to apply reductions under the HMF and HUF to the DSH allotment that the state would have had available during the demonstration year (DY) coinciding with the SPRY DSH audits utilized in the DHRM. It would prorate the FFY allotment amount to determine this reduction in cases where the DY of the section 1115 demonstration crosses two FFYs.

CMS adds that if a state that diverts its entire DSH allotment has a DY that begins July 1, 2018, and ends June 30, 2019, the agency would have to determine the reduction amount associated with the diverted DSH allotment to reflect the amount of the FFY 2018 DSH allotment available from July 1, 2018, through September 30, 2018, and the amount of FFY 2019 DSH allotment available from October 1, 2018, through June 30, 2019. For a state that diverts part of its DSH allotment, it would have a SPRY DSH audit already utilized in the DHRM.

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

As noted above, section 203 of the CAA, 2021 changed the methodology for calculating the Medicaid shortfall portion (i.e., Medicaid costs less Medicaid payments) of the hospital-specific DSH limit to only include costs and payments for hospital services furnished to beneficiaries for whom Medicaid is the primary payer. It also provides an exception for 97$^{th}$ percentile hospitals with respect to which the limit is equal to the higher of the limit calculated under the methodology in existence before January 1, 2020 (referred to in this summary as the pre-CAA, 2021 methodology) and the methodology established by the CAA, 2021.

The proposed changes would apply for SPRYs (as opposed to fiscal years) beginning on or after October 1, 2021. CMS believes this is consistent with its past implementation of statutory effective dates for section 1923 of the SSA and that using the SPRY would avoid excessive burden on states and hospitals that would be posed if the changes were implemented on the basis of an FY.

*a. Definition of 97$^{th}$ Percentile Hospital*

CMS proposes to add a definition of 97$^{th}$ percentile hospitals to §447.295(b) as follows:

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

Under the proposal, for each Medicaid SPRY beginning on or after October 1, 2021, CMS would prospectively identify the 97$^{th}$ percentile hospitals, using Medicare cost reporting and claims data sources, as well as SSI eligibility data provided by the Social Security Administration. It would also publish lists identifying each 97$^{th}$ percentile hospital annually in advance of October 1 of

each year. It would only revise a published list to correct a mathematical or other similar technical error that is identified to CMS during the one-year period beginning on the date the list is published.

The agency proposes to develop a data set, compiling cost report, claims, and eligibility data, to prospectively determine which hospitals, ranked on a national level, qualify to meet the statutory 97$^{th}$ percentile hospital exception. It would publish these data annually, and it reiterates that these determinations would be done on the basis of SPRYs and not FFYs. CMS believes applying this exception prospectively eliminates the need to retroactively rank and qualify hospitals based on actual Medicare SSI days and ratios for services furnished during the SPRY and provides more predictability for states and hospitals.

It proposes to determine each hospital's Medicare SSI days for discharges occurring in the hospital's most recent cost reporting period, regardless of the length of that cost reporting period, using a data set that combines Medicare Provider Analysis and Review (MEDPAR) claims data and SSI eligibility data. To determine each hospital's percentage of Medicare SSI days to total inpatient days, CMS proposes to divide the Medicare SSI days by each hospital's total inpatient days for that same cost reporting period from Healthcare Cost Report Information System (HCRIS) to obtain a percentage. Then, it would compile two lists, ranking hospitals based on the absolute number of Medicare SSI days, and the percentage of inpatient days that are Medicare SSI days, respectively. A hospital could qualify to meet the 97$^{th}$ percentile exception on the basis of either of the two lists. For the Medicare SSI days, the 97$^{th}$ percentile threshold would be rounded to the nearest whole number, with x.5 or higher rounded up, and less than x.5 rounded down. For the percentage of inpatient days that are Medicare SSI days, all values would be rounded to the fourth decimal place, including each hospital's own percentage and the 97th percentile threshold. Values of 0.xxxx5 or higher would be rounded up, and less than 0.xxxx5 would be rounded down.

CMS proposes to utilize information from the most recent cost reporting period using an "as-submitted" cost report. However, if that most recent cost reporting period for which there is an as-submitted cost report already has an amended cost report, a settled cost report, or a reopened cost report as of the date that CMS obtains data from HCRIS, it would use the total inpatient day count from that amended cost report, settled cost report, or reopened cost report, as the case may be, for that period.

The agency also proposes to use both covered and non-covered Medicare Part A days when collecting data and calculating hospital percentiles. Further, it would include days furnished in distinct part units of the hospital that provide inpatient hospital services to determine a hospital's Medicare SSI days and total inpatient days.

CMS proposes to collect data from the HCRIS as of March 31 before the beginning of a SPRY. Similarly, MEDPAR files and SSI eligibility data would be as of that same March 31 date. It believes this snapshot would provide the most recent data to apply to the upcoming SPRY. Noting that some hospitals could be omitted from the data set (e.g., because of late filing of a cost report), it proposes to include in the data set any hospital that has filed a cost report dating back to at least September 30 from 3 years before in order to capture as many hospitals as

possible in the data set. CMS emphasizes that it will use only data from hospitals that file a Medicare cost report.

The agency would not modify the 97th percentile qualification results based on a request by one or more individual hospitals (or by one or more states, with respect to one or more individual hospitals) to update or reconsider hospital cost report, claims, or eligibility data. However, where CMS has made a mathematical or technical error, it proposes to allow 1 year from the posting of the 97th percentile hospital lists for states, hospitals, CMS, or other interested parties to identify any mathematical or other similar technical error. Upon CMS verification that an error occurred that affected the hospitals appearing on a list of 97th percentile hospitals for a given year, it would determine and publish a revised list as soon as practicable.

*b. Calculation of Hospital-specific DSH Limit*

CMS proposes to amend its regulation §447.295(d) to clarify the two different calculation methodologies and their application. Specifically, it would designate the pre-CAA, 2021 methodology) as paragraph (1) with modifications to reflect its general application before October 1, 2021, as well as the exception of its continued application after that date for 97th percentile hospitals. The proposal would also add the CAA-methodology in paragraph (2) with an effective date of SPRYs beginning on or after October 1, 2021 with a similar exception for 97th percentile hospitals. Finally, the special rule for 97th percentile hospitals that provides for the higher of the limits calculated under the two methodologies would be added in paragraph (3).

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

CMS proposes to eliminate the regulatory requirement to publish annual DSH allotments in the Federal Register from its regulations; it would instead post that information, as well as preliminary and final national expenditure targets, on its Medicaid.gov website and in the Medicaid Budget and Expenditure System/State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES).

It would also strike the specific date (April 1) by which final national targets and allotments must be published and instead indicate that they must be published as soon as practicable. Similarly, it would remove the April 1 publication date to allow for Medicaid expenditures associated with the FFY DSH allotment to be finalized.

5. Reporting Requirements (§447.299)

*a. Calculating Medicaid Shortfall*

CMS proposes to revise its existing DSH reporting requirements in clauses (6), (7), (10) and (16) of §447.299(c) to reflect the changes made by section 203 of the CAA, 2021 (i.e., only including costs for which Medicaid is the primary payer and the 97th percentile hospital exception described above). The proposals would remove all the references in these clauses to Medicaid eligible individuals and update the text to indicate that only payments or costs, as the case may be, reported in accordance with §447.295(d) (see section II.3. above) should be included in this data element.

The effective date for this proposal would be applicable to FYs beginning on or after October 1, 2021, which aligns with the effective date of the CAA, 2021.

*b. Reporting DSH Overpayments*

CMS proposes to add a new data element to the existing DSH reporting requirements. CMS would re-designate existing paragraph (c)(21) as (c)(22) and add a new (c)(21) requiring states to include in annual DSH reports the financial impact associated with audit findings. CMS states that this data element would improve the accuracy of identifying overpayments discovered in the DSH audit process and explains that audit findings could be related to missing or improper data, lack of documentation, non-compliance with federal statutes and/or regulations or other identified deficiencies.

For purposes of this requirement, an audit finding would mean an issue identified in the independent certified audit required under §455.304 about the methodology for computing the hospital-specific DSH limit or the DSH payments made to the hospital, including compliance with the hospital-specific DSH limit as defined in §447.299(c)(16). CMS believes that requiring the quantification of these findings would limit the burden on states and CMS of performing follow-up reviews or audits. The agency notes that auditors would have the professional discretion and the flexibility to determine how to best quantify these amounts in the audit findings. However, if the actual financial impact could not be calculated, CMS would require a statement of the estimated financial impact for each audit finding identified in the independent certified audit that is not reflected in the other data elements identified in §447.299(c).

The agency proposes to define actual financial impact as the total amount associated with audit findings calculated using the documentation sources identified in §455.304(c). The estimated financial impact would mean the total amount associated with audit findings calculated on the basis of the most reliable available information to quantify the amount of an audit finding in circumstances where complete and accurate information necessary to determine the actual financial impact is not available from the documentation sources identified in §455.304(c).

CMS also proposes to codify its policy for the handling and reporting of overpayments identified through the annual independent certified DSH audits in a new paragraph (f) of §447.299. Under the policy, DSH payments that were found in the independent certified audit process to exceed hospital-specific cost limits are provider overpayments that must be returned to the federal government, or redistributed by the state to other qualifying hospitals, if redistribution is provided for under the approved Medicaid State plan.

In a new paragraph (g) of §447.299, states would be required to report any overpayment redistribution amounts to CMS using Form CMS-64 within 2 years from the date of discovery that a hospital-specific limit has been exceeded, as determined under §433.316(f) in accordance with a redistribution methodology in the approved Medicaid State plan. The state would have to report redistribution of DSH overpayments as separately identifiable decreasing adjustments reflecting the return of the overpayment and increasing adjustments representing the

redistribution by the state. Both adjustments would have to correspond to the fiscal year DSH allotment and Medicaid SPRY of the related original DSH expenditure claimed by the state.

**CMS invites comments on these proposals.**

6. Definitions (§455.301)

CMS proposes what amounts to a conforming change to the current definition of the "independent certified audit" to include the requirement for auditors to quantify the financial impact of each audit finding, or caveat, on an individual basis, for each hospital, per the proposed new reporting requirement in §447.299(c)(21) (described in section II.5.b. above). **CMS seeks comment on this proposed change.**

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

CMS proposes what are conforming changes to the requirements for independent certified audit verifications to reflect its proposals to revise the independent certified data elements at §447.299(c)(6), (7), (10), and (16) (described in section II.5.a. above). The proposed modifications to clauses (1), (3), (4), and (6) of §455.304(d) reflect the statutory changes made by section 203 of the CAA, 2021 updating the independent certified audit verifications as they relate to the treatment of Medicaid eligibles and third-party payers.

Essentially, the proposals would all remove the reference in these clauses to Medicaid eligible individuals and update the text to indicate that only payments or costs, as the case may be, are determined in accordance with §447.295(d) (see section II.3. above). Thus, the changes made by section 203 of the CAA, 2021 (i.e., only including costs for which Medicaid is the primary payer and the 97$^{th}$ percentile hospital exception described above) would be incorporated into the requirements for independent certified audit reports.

This proposal would be applicable to fiscal years beginning on or after October 1, 2021, which aligns with the effective date of the CAA, 2021.

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

CMS has not published CHIP allotments in the Federal Register since the FY 2013 CHIP allotments; instead, it has notified states of their CHIP allotments through email notifications or MBES/CBES. It proposes to strike from §457.609(h) its option to publish in the Federal Register the national CHIP allotment amounts and to instead post CHIP allotments in the MBES/CBES and at Medicaid.gov (or similar successor systems or websites) annually. **It seeks comment on this proposal.**

## III. Retroactive Application of the Rule

As it has noted throughout the preamble of the proposed rule, CMS reiterates that section 203 of the CAA, 2021, requires that changes to the calculations of Medicaid hospital-specific DSH limits take effect on October 1, 2021, and apply to payment adjustments made under section

1923 of the Act during fiscal years beginning on or after that date. If finalized, the provisions of the rule will apply retroactively.

## IV. Information Collection Requirements

The rule establishes a new mandatory reporting requirement and modifies some existing audit requirements. The proposed requirements would create a total annual burden of 153 hours at a cost of $14,420 and an average per state burden of 3 hours (153 hr / 51 states) and $282.75 ($14,420 / 51 states). That impact is shown in Table 2 of the proposed rule (reproduced below).

**Table 2: Proposed Annual Recordkeeping and Reporting Requirements**

| Regulation Section(s) under Title 42 of the CFR | OMB Control Number (CMS ID Number) | Respondents | Responses (per state) | Total Responses | Time per Response (hours) | Total Annual Time (hours) | Labor Costs ($/hr) | Total Cost ($) |
|---|---|---|---|---|---|---|---|---|
| §447.299 DSH audit | 0938-0746 (CMS-R-266) | 50 | 1 | 51 | 2 | 102 | Varies | 10,100 |
| | | 50 | 1 | 51 | 1 | 51 | 80.74 | 4,037 |
| **Total** | | **50** | **2** | **102** | **Varies** | **153** | **Varies** | **14,137** |

## V. Regulatory Impact Analysis

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

Based on its estimates using a "no action" baseline, OMB's Office of Information and Regulatory Affairs has determined that this rulemaking is "economically significant." This "no action" baseline incorporates the statutory changes made by the CAA that do not require rulemaking to be in effect, such as the change to the definition of Medicaid shortfall. Additionally, the rule is not expected to have a significant impact on a substantial number of small entities.

CMS estimates the overall burden of adding the requirement for the calculation of the hospital-specific DSH limit for hospitals meeting the exception for 97$^{th}$ percentile hospitals as follows.

For states to assess which hospitals meet the exception, CMS estimates approximately 2 hours (1 hour at $77.28/hr for a financial specialist to prepare a spreadsheet report, and 1 hour at $124.72/hr for management and professional staff to review the report). In the aggregate, CMS estimates an ongoing annual burden of 102 hours (51 states x 2 hr/response x 1 response/year) at a cost of $10,302. Additionally, state auditors would spend an additional hour verifying the hospital-specific DSH limits for hospitals meeting the exception for 97th percentile hospitals. The estimated annual burden would be 1 hour per state (51 states x 1 hour) 51 hours x $80.74/hr

for auditors to complete the audit at a cost of $4,118 per year. The total cost of this provision would be $14,420 ($10,302 + $4,118) and 153 hours, or $282.74 and 3 hours per state.

The additional DSH audit data reporting element creates a burden of 153 hours at a cost of $14,420, with an average of 3 hours, at a cost of $282.74 per state Medicaid agency per year.

CMS does not estimate any cost impact related to the DHRM BNF proposal because it merely clarifies how amounts are determined, and the impact of the policy itself was accounted for the in the 2019 final rule that finalized the factor amounts. Similarly, no cost impact is estimated for the proposals to publish DSH and CHIP allotments through an alternative means.

CMS says the benefits of the rule include enhanced federal oversight of the Medicaid DSH program, improved accuracy of DSH audit overpayments identified through and collected as a result of annual DSH audits, clarity on certain existing Medicaid DSH policies, and reduced administrative burden.

CMS notes that the proposed rule policies would affect the calculation of the hospital-specific DSH limit established at section 1923(g) of the Act, and some providers may see a decrease in their historic hospital-specific DSH limits. However, these effects are a direct result of statutory changes rather than the regulatory ones. CMS observes that some providers may see an increase in their historic hospital-specific DSH limits, but this is again by reason of statutory rather than regulatory changes. It is also possible that lower hospital-specific DSH limits for some hospitals may result in states choosing to distribute higher DSH payments to hospitals that historically had not been paid at higher levels. CMS believes that its proposals would not affect the flexibility afforded states in setting DSH payment methodologies to the extent that these methodologies are consistent with section 1923(c) of the Act and all other applicable statutes and regulations.

CMS describes at length alternative policies it considered for the data sources used for purposes of determining whether a hospital qualifies as a 97$^{th}$ percentile hospital.