

**DEPARTMENT OF HEALTH AND HUMAN SERVICES****Centers for Medicare & Medicaid Services****42 CFR Part 447****[CMS-2315-F]****RIN 0938-AQ37****Medicaid Program; Disproportionate Share Hospital Payments – Uninsured Definition****AGENCY:** Centers for Medicare & Medicaid Services (CMS), HHS.**ACTION:** Final rule.

**SUMMARY:** This final rule addresses the hospital-specific limitation on Medicaid disproportionate share hospital (DSH) payments under the Social Security Act (the Act). Under this limitation, DSH payments to a hospital cannot exceed the uncompensated costs of furnishing hospital services by the hospital to individuals who are Medicaid-eligible or “have no health insurance (or other source of third party coverage) for the services furnished during the year.” This rule provides that, in auditing DSH payments, the quoted test will be applied on a service-specific basis; so that the calculation of uncompensated care for purposes of the hospital-specific DSH limit will include the cost of each service furnished to an individual by that hospital for which the individual had no health insurance or other source of third party coverage.

**DATES:** Effective December 31, 2014.

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**SUPPLEMENTARY INFORMATION:****I. Background****A. Introduction**

On December 19, 2008, we published a final rule in the **Federal Register** (73 FR 77904)

entitled “Medicaid Disproportionate Share Hospital Payments” (hereinafter referred to as the 2008 DSH final rule) that implemented section 1001 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) (Pub. L. 108-173), requiring State reports and audits to ensure the appropriate use of Medicaid Disproportionate Share Hospital (DSH) payments and compliance with the DSH limit imposed at section 1923(g) of the Social Security Act (the Act). The limit at section 1923(g) of the Act is commonly referred to as the hospital-specific DSH limit and specifies that only the uncompensated costs of providing inpatient hospital and outpatient hospital services to Medicaid eligible individuals and uninsured individuals as described in section 1923(g)(1)(A) of the Act are included in the calculation of the hospital-specific DSH limit. The statute describes uninsured individuals as those “who have no health insurance (or other source of third party coverage) for the services furnished during the year.”

Citing an effort to adhere to an accurate representation of the broad statutory references to insurance or other coverage and to delineate more definitively the meaning of the term uninsured, we defined the phrase “who have health insurance (or other third party coverage)” to refer broadly to individuals who have creditable coverage consistent with the definitions under 45 CFR Parts 144 and 146, as well as individuals who have coverage based upon a legally liable third party payer. This regulatory definition was not the same as the preliminary guidance previously issued to states and providers in 1994.

In an August 17, 1994 letter to State Medicaid Directors (SMD), CMS included a summary of the DSH provisions in the Omnibus Budget Reconciliation Act of 1993 (OBRA 93) (Pub. L. 103-66), as a preliminary interpretation. In that letter, we endorsed a service-specific approach in which individuals were considered “uninsured” for purposes of DSH to the extent that they did not have third party coverage for the specific hospital service that they received. A January 10, 1995 letter to the Chair of the State Medicaid Director’s Association affirmed the service-specific interpretation of the definition of uninsured by clarifying that: “it would be permissible for States to include in their determination of uninsured patients those individuals who do not possess health

insurance, which would apply to the service which the individual sought”.

The regulatory definition published in the 2008 DSH final rule was more restrictive than the service-specific definition and is applied on an individual-specific basis rather than a service-specific basis. This interpretation of the definition of “uninsured” superseded all prior interpretive issuances.

After publication of the 2008 DSH final rule, numerous states, members of the Congress, and related stakeholders expressed their concern that the 2008 DSH final rule definition of the uninsured deviated from prior guidance and would have a significant financial impact on states and hospitals. This final rule is designed to mitigate some of the unintended consequences of the uninsured definition put forth in the 2008 DSH final rule and to provide additional clarity on which costs can be considered uninsured costs for purposes of determining the hospital-specific limit. Specifically, this final rule’s interpretation and definition of “uninsured” affords states and hospitals maximum flexibility permitted by statute in calculating the hospital-specific DSH limit. Although this rule’s definition of uninsured may affect the calculation of the hospital-specific DSH limit, the final rule does not modify the DSH allotment amounts and will have no effect on a state’s ability to claim FFP for DSH payments made up to the published DSH allotment amounts.

#### **B. Legislative History**

Title XIX of the Act authorizes federal grants to states for Medicaid programs that provide Medical assistance to low-income families, the elderly, and persons with disabilities. Section 1902(a)(13)(A)(iv) of the Act requires that states make Medicaid payment adjustments for hospitals that serve a disproportionate share of low-income patients with special needs. Section 1923 of the Act contains more specific requirements related to the DSH payments.

The OBRA 93 was signed into law on August 10, 1993. Section 13621 of OBRA 93 added section 1923(g) of the Act, limiting Medicaid DSH payments to a qualifying hospital to the amount of eligible uncompensated costs incurred. This hospital-specific limit requires that Medicaid DSH payments to a qualifying hospital not exceed the costs incurred by that hospital for

providing inpatient and outpatient hospital services furnished during the year to Medicaid patients and individuals who have no health insurance or other source of third party coverage for the services provided during the year, less applicable revenues for those services.

C. Hospital-specific DSH Limit

Section 1923(g)(1) of the Act defines a hospital-specific limit on Federal financial participation (FFP) for DSH payments. Each state must develop a methodology to compute this hospital-specific limit for each DSH hospital in the state. As defined in section 1923(g)(1) of the Act, the state's methodology must calculate for each hospital, for each fiscal year, the costs incurred by that hospital for furnishing inpatient hospital and outpatient hospital services during the applicable state fiscal year to Medicaid individuals and individuals who have no health insurance or other source of third party coverage for the inpatient hospital and outpatient hospital services they receive, less all applicable revenues for these hospital services. This difference, if any, between incurred inpatient hospital and outpatient hospital costs and associated revenues is considered a hospital's uncompensated care cost (UCC) limit, or hospital-specific DSH limit. FFP is not available for DSH payments that exceed a hospital's UCC for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individuals and individuals who have no health insurance or other source of third party coverage for the services they receive in any given state plan rate year.

To be considered as an inpatient or outpatient hospital service for purposes of Medicaid DSH, a service must meet the federal and state definitions of an inpatient hospital service or outpatient hospital service and must be included in the state's definition of an inpatient hospital service or outpatient hospital service under the approved state plan. While states may have some flexibility to define the scope of inpatient or outpatient hospital services, states must use consistent definitions. Hospitals may engage in any number of activities, or may furnish practitioner, nursing facility, or other services to patients that are not within the scope of inpatient hospital services or outpatient hospital services. These services are not considered inpatient or outpatient hospital

services for purposes of the Medicaid DSH calculations.

Sections 1923(a) and 1923(c) of the Act provide states some latitude in determining the level of DSH payment under the Medicaid State plan. Section 1923(g) of the Act, however, provides for hospital-specific limitations on FFP for DSH payments to individual hospitals. These limits provide that FFP is not available in payments that exceed the level of costs that are considered uncompensated care costs (UCCs) that are specifically defined as certain net costs. The first component of the net costs is described in statute as attributable to hospital costs incurred by individuals eligible for medical assistance under the state plan and net of payments made under title XIX of the Act. We currently implement this provision by allowing all medically necessary inpatient and outpatient costs associated with Medicaid eligible individuals authorized under section 1905 of the Act and covered under the approved Medicaid State plan regardless of whether those beneficiaries or hospitals were entitled to payment as part of the Medicaid benefit package under the state plan. To arrive at uncompensated Medicaid costs, all Medicaid payments received from the state for Medicaid hospital services, including supplemental payments, must be netted against those costs.

The second type of costs allowable as part of the Medicaid DSH limit are described in statute as attributable to hospital costs incurred by individuals who have no health insurance or other source of third party coverage for services furnished during the year. To arrive at uncompensated costs for these services, all payments received for that care must be netted against those costs (without regard to whether the hospital received payments for services provided to indigent patients by a state or local governmental unit).

#### D. CMS Guidance Regarding the Definition of Uninsured

Following the passage of the OBRA 93, we did not issue a rule implementing section 1923(g) of the Act. However, we did receive questions concerning the implementation of section 1923(g) of the Act from states, including many regarding the criteria used to determine which of a hospital's patients "have no health insurance or other source of third party coverage for the

services provided.” In response to these questions, we issued a letter on August 17, 1994 to all SMD’s delineating the Agency’s interpretation of statutory provisions of section 13621 of OBRA 93.

The SMD letter specifically established our interpretation of the term “uninsured” patients for purposes of the calculating OBRA 93 DSH limits. We developed a definition of “individuals who have no health insurance or other source of third party coverage for the services provided” based on the statutory language linking coverage and the provision of services throughout the year in which the service was provided. The August 17, 1994 SMD letter articulated this policy interpretation by stating that individuals who have no health insurance (or other source of third party coverage) for the services provided during the year include those “who do not possess health insurance, which would apply to the service the individual sought treatment.” We affirmed this guidance in a January 10, 1995 letter to the Chair of the SMD’s Association. This interpretation remained in effect until the January 19, 2009 effective date of the 2008 DSH final rule implementing the DSH auditing and reporting requirements.

#### E. MMA and the 2008 DSH Final Rule

Several United States Department of Health & Human Services Office of Inspector General (OIG) audits and United States Government Accountability Office (GAO) reports detailing improper DSH expenditures in some states, raised concern that we did not have sufficient authority to appropriately monitor state compliance with section 1923 of the Act. In particular, concerns were expressed that states were not enforcing the OBRA 93 limits on DSH expenditures. Subsequently, Congress include in the MMA section 1001(d) , which added new audit and reporting requirements to the Act. Specifically, it added section 1923(j)(1) of the Act, which requires states to submit an annual report and audit to ensure the appropriate compliance with DSH limits imposed at section 1923(g) of the Act.

In promulgating the 2008 DSH final rule, we defined the phrase “who have health insurance (or other third party coverage)” by referencing individuals who have a legally liable

third party payer for the services provided by a hospital and by referencing regulations that define creditable coverage under 45 CFR Parts 144 and 146. The regulatory definition of creditable coverage in Parts 144 and 146 was developed to implement, in part, the Health Insurance Portability and Accountability Act (HIPAA) of 1996 (Pub. L. 104-191) and was designed to offer protection to the broadest number of individuals. This definition of creditable coverage, which did not exist in 1994 when we issued initial guidance on the Medicaid DSH definition of uninsured, is applied on an individual-specific basis (that is, does an individual have coverage) rather than on the existing service-specific interpretation (that is, does an individual have coverage for a service). Creditable coverage includes coverage of an individual under a group health plan, Medicare, Medicaid, a medical care program of the Indian Health Service (IHS) or tribal organization, and other examples as outlined in the rules relating to creditable coverage at §146.113.

The new interpretation of the definition of “individuals who have no health insurance or other source of third party coverage for the services provided” articulated in the 2008 DSH final rule, which relied on the existing regulatory definition of creditable coverage, superseded all prior interpretive issuances.

#### F. Concerns Raised

Numerous states, members of the Congress, hospitals and related stakeholders expressed concerns following the publication of the 2008 DSH final rule that the rule’s definition of uninsured individuals would have a significant negative financial impact on states and hospitals. As states and hospitals began to complete the initial audits as defined in the final rule, they identified specific issues relating to the regulatory definition of uninsured adopted under the rule. Specific consequences regarding the practical application of the creditable coverage definition were identified and some stakeholders questioned the impact of the new definition of uninsured as it relates to individuals who had IHS and tribal health coverage for services and individuals who had exhausted their insurance benefits or who had reached their lifetime insurance limits. Uncompensated costs to hospitals for these services were no longer eligible DSH costs under the

creditable coverage definition applied in the 2008 DSH final rule.

The issue involving IHS and tribal programs arises because IHS coverage is within the scope of “creditable coverage” under the regulations in Parts 144 and 146, and thus individuals with this coverage could not be considered “uninsured” even if the IHS or tribal health program did not provide the service or authorize coverage through the contract health service program (through a purchase order or equivalent document). In that circumstance, the hospital would not be able to count, as costs eligible for Medicaid DSH payments, costs of uncompensated care associated with the provision of inpatient or outpatient hospital services to American Indians/Alaska Natives with access to IHS and tribal coverage (but no other source of third party payment).

The IHS and Tribal health programs provide two primary types of services: direct health care services and contract health services. Direct health care services are oftentimes limited to primary care services and are limited to eligible beneficiaries identified at 42 CFR §136.12. Many of the beneficiaries that receive direct care services have no other source of third party coverage. Contract health services (CHS) are services provided outside of an IHS or Tribal facility to an eligible beneficiary (§136.23). CHS appropriations are discretionary; therefore, coverage is determined based on a priority system. Coverage for CHS services is specifically authorized on a case-by-case basis through a CHS purchase order or equivalent document. IHS and tribal health programs can also issue referrals that do not authorize CHS coverage of a service.

For Medicaid DSH purposes, we believe that American Indians/Alaska Natives are considered to have third party coverage for inpatient and outpatient hospital services received directly from IHS or tribal health programs (direct health care services) and for services specifically authorized under CHS. The service-specific determination of third party coverage status of American Indian/Alaska Natives for services not authorized to be within the scope of coverage by CHS should be made consistently with determinations made for non-IHS patients. This is the same treatment that, as we describe below, we will give to these services that are



outside the scope of coverage from any other insurer or third party payer.

The second issue concerns the interaction between the creditable coverage definition in the 2008 DSH final rule and hospital services provided to individuals with creditable coverage but without coverage for specific hospital services received. By using the current regulatory creditable coverage definition, an individual is considered either to have coverage, as broadly described in regulations, or not to have coverage during the period a hospital service was provided. Under the 2008 DSH final rule, if an individual had creditable coverage at the time of the service, that individual was not considered uninsured and the service costs would be excluded from the hospital-specific DSH limit calculation. In practical application, this definition appeared to exclude from uncompensated care for DSH purposes the costs of many services that were provided to individuals with creditable coverage but were outside the scope of coverage. Costs affected include those associated with individuals who have exhausted their insurance benefits or who have reached lifetime insurance limits for certain services, as well as services not included in a benefit package as covered, but those identified in section 1905 of the Act and covered under the approved Medicaid State plan.

For purposes of defining uncompensated care costs for the Medicaid hospital-specific DSH limit, we believe that uncompensated costs of providing inpatient and outpatient hospital services to individuals who do not have coverage for those specific services should be considered costs for which there is no liable third party payer and thus eligible costs for Medicaid DSH payments. An example of a situation involves an individual with basic hospitalization coverage that has an exclusion for transplant services. Should the individual need the excluded service, the cost of that service could be included in the Medicaid hospital-specific DSH limit. Another example involves an individual with excluded benefits or services, or exhaustion of coverage or benefits for a limited covered service, due to a pre-existing condition (for example, cancer or diabetes). Although both examples involve medically necessary services for which an individual is uninsured, associated costs would have been prohibited from inclusion in calculating the

hospital-specific DSH limit based on the 2008 DSH final rule and related guidance.

If an individual is Medicaid eligible, all costs incurred in providing inpatient and outpatient hospital services identified in section 1905 of the Act and covered under the approved Medicaid state plan should be included in calculating Medicaid hospital costs, not uninsured hospital costs, for purposes of calculating the hospital-specific DSH limit, regardless of whether the individual's benefits have been exhausted or whether coverage limits have been reached.

## **II. Provisions of the Proposed Regulations and Analysis of and Responses to Public**

### **Comments**

On January 18, 2012, we published a proposed rule entitled, Disproportionate Share Hospital Payments-Uninsured Definition (hereinafter referred to as the 2012 DSH proposed rule). In that rule, we proposed to add a new 42 CFR 447.298-- Hospital-Specific Disproportionate Share Hospital Payment Limit-Definition of Individuals Who have no health Insurance (or Other Source of Third Party Coverage). Specifically, we proposed to describe the scope of the new regulation section and define the following terms:

- Individuals who have no health insurance (or other source of third party coverage) for the services furnished during the year.
- Health insurance coverage limit.
- No source of third party coverage for a specific inpatient hospital or outpatient service.
- Determination of an Individual's Third Party Coverage Status.
- Service-Specific Coverage Determination.

In response to the 2012 DSH proposed rule, we received 71 public comments from State Medicaid agencies, provider associations, providers, and other interested parties. The following is a brief summary of each proposed provision, a summary of the public comments that we received related to that proposal, and our responses to the comments.

#### A. Effective Date

We proposed this final rule effective for DSH audits and reports submitted for state plan rate year 2011 and after, which are due to CMS on December 31, 2014. In this final rule, we are making the effective date December 31, 2014. Medicaid DSH audits and reports required by section 1923(j) of the Social Security Act due to CMS on or after this date should rely on the provision of this final rule. We will continue to provide technical assistance and guidance to states to assure compliance with section 1923(j) of the Act. Comments and our response to comments on the effective date are as follows:

Comment: Many commenters requested clarification on the effective date of the rule. Specifically, the commenters wanted to know which DSH audit year the modified definition of uninsured would apply to and made various suggestions regarding the effective date and the application of the modified definition. Some commenters suggested that CMS make this final rule effective retroactive to the effective date of the 2008 DSH final rule and requested that CMS rescind the discussion of creditable coverage in that rule (that is, the 2008 DSH final rule). Other commenters suggested CMS clarify if states could use either definition for periods prior to the effective date of this rule. Some commenters requested that CMS specify whether the new definition of uninsured would be applicable to pending DSH audits and reports and requested that CMS extend the deadline for states to submit pending DSH audits and reports so that accurate data on costs and payments allowable under the definition will be captured.

Response: This final rule has an effective date of December 31, 2014. We did not see a clear basis consistent with the requirements of the Administrative Procedure Act to make this rule retroactive. The provisions of this final rule will thus apply to audits due on or after that date. The first Medicaid State Plan Rate Year (SPRY) for which audits are due after that date, to which the modified definition of uninsured is applicable, is SPRY 2011. We believe that this effective date will provide states and hospitals with adequate time to implement any necessary changes to their administrative process. Therefore, we are not extending the submission deadline for any DSH audits and reports.

## B. Medicaid Eligible Individuals

DSH payments are limited to the hospital-specific limit defined in section 1923(g)(1) of the Act. For each fiscal year, the state must calculate this limit for each hospital. We proposed that the limit is the costs incurred by that hospital for furnishing inpatient hospital and outpatient hospital services during the applicable state fiscal year to Medicaid individuals and individuals who have no health insurance or other source of third party coverage for the inpatient hospital and outpatient hospital services they receive, less all applicable revenues for these hospital services.

If an individual is Medicaid eligible, all costs incurred in providing inpatient and outpatient hospital services identified in section 1905 of the Act and covered under the approved Medicaid state plan should be included in calculating Medicaid hospital costs, not uninsured hospital costs, for purposes of calculating the hospital-specific DSH limit, regardless of whether the individual's benefits have been exhausted or whether coverage limits have been reached. Comments and our response to comments on Medicaid eligible individuals are as follows:

Comment: Several commenters requested clarification on the inclusion of hospital costs relating to services furnished to Medicaid eligible individuals for purposes of calculating the hospital-specific DSH limit. A few commenters wanted clarification that costs of services furnished to Medicaid eligible individuals who have exhausted hospital benefits available under a state's Medicaid program will be included in the hospital-specific DSH limit calculation. Another commenter stated that the cost of hospital services furnished to Medicaid eligible individuals that are beyond state plan service limits would be allowable as uninsured costs when calculating the hospital-specific DSH limit.

Response: We clarify that the cost of inpatient hospital and outpatient hospital services furnished to a Medicaid eligible individual who has exhausted applicable state coverage limits, and has no other source of third party coverage for the specific service, can be included as Medicaid shortfall in the hospital-specific DSH calculation.

Comment: A few commenters requested clarification regarding the inclusion of inpatient

hospital service costs and revenues in the hospital-specific DSH limit when an individual's Medicaid eligibility status ends prior to the completion of their inpatient stay. Commenters noted that under some Medicaid programs, hospitals are reimbursed by Medicaid on a per diem basis and may only bill for the days when patients are Medicaid eligible. For the days of care furnished when patients are not Medicaid eligible, the commenter requested clarification if the days of care would be considered uninsured for DSH purposes.

Response: The hospital-specific limit is calculated by determining the uncompensated costs incurred in furnishing inpatient and outpatient hospital services to Medicaid eligible individuals and uninsured individuals. This final rule establishes a single determination of whether costs and revenues associated with a particular service are included in the hospital-specific DSH limit calculation. If an individual is Medicaid eligible for any day during a single inpatient stay for a particular service, states must classify the individual as Medicaid eligible for all costs and revenues associated with that particular service, including, but not limited to, revenues from all third party payors. If the individual is not Medicaid eligible and has a source of third party coverage for all or a portion of the single inpatient stay for a particular service, states cannot include any costs and revenues associated with that particular service when calculating the hospital-specific DSH limit. If the individual has no source of third party coverage for the specific inpatient hospital or outpatient hospital service furnished by the hospital, states should classify the individual as uninsured for the particular service and include the costs and revenues associated with that particular service when calculating the hospital-specific DSH limit.

Comment: A few commenters requested clarification with respect to Medicaid spend-down. States impose monthly or other periodic "spend-down" requirements on individuals that must be met for their incomes to qualify under Medicaid income eligibility criteria. Until an individual has satisfied his or her spend-down requirements, medical assistance is unavailable for services provided and these individuals must incur medical costs out-of-pocket. Commenters expressed that it is appropriate to treat these individuals as uninsured patients for services

furnished to them prior to meeting Medicaid spend-down requirements.

Response: To the extent that Medicaid does make any payment for a specific inpatient or outpatient hospital service furnished by the hospital to an individual who has not met spend-down obligations, and the individual has no source of third party coverage for the specific service, states must classify the individuals as uninsured for purposes of the hospital-specific DSH limit. After the individuals have been determined Medicaid eligible after meeting Medicaid spend-down requirements, states must classify them as Medicaid eligible for purposes of the hospital-specific DSH limit.

#### Uninsured and Underinsured Individuals

Comment: A few commenters expressed concern about patients who are severely underinsured. One commenter provided a situation where the cost to provide care for a 7-day inpatient stay was approximately \$7,000, but the patient's hospital insurance only paid the hospital approximately \$2,250. The commenter asked CMS to define an exception that would allow these patients to be considered uninsured for purposes of the hospital-specific DSH limit.

Response: To the extent that the hospital received payment for the service consisting of a 7-day hospital stay, the individual was "insured" for that specific service. Only the uncompensated costs of providing inpatient hospital and outpatient hospital services to Medicaid eligible individuals and uninsured individuals as described in section 1923(g)(1)(A) of the Act are included in the calculation of the hospital-specific DSH limit. The statute describes uninsured individuals as those "who have no health insurance (or other source of third party coverage) for the services furnished during the year." We do not have the authority to craft an exception to include insured individuals whose insurance does not pay the full cost of covered services.

Comment: A few commenters suggested that CMS should modify the definition of "no source of third party coverage" for a specific inpatient or outpatient hospital service under §447.295(b) because it mentions only annual or lifetime limits. Commenters also suggested that CMS should revise the regulatory language to explicitly capture cost for individuals who "have

exhausted covered benefits.”

Response: We have revised the regulations text to clarify that individuals who have exhausted benefits before obtaining services will be considered uninsured. In contrast, individuals who exhaust covered benefits during the course of a service will not be considered uninsured for that particular service. We will work with states and stakeholders to ensure that all stakeholders receive clear federal and state guidance regarding service-specific coverage determinations.

Comment: A few commenters stated that the final rule should define whether an individual is uninsured on a service-specific basis.

Response: This final rule implements a service-specific approach to define individuals who have no health insurance (or source of third party coverage) for purposes of calculating the hospital-specific DSH limit.

Comment: Several commenters requested that Medicaid eligible individuals who have private insurance should be excluded from the hospital-specific DSH limit calculation. In determining uncompensated care, CMS requires hospitals to take into account all revenues and costs associated with the care and treatment of Medicaid patients. When Medicaid patients also have insurance, the commenters suggest factoring payments from commercial insurance may artificially lower a hospital’s DSH limit, especially if the hospital serves a high percentage of Medicaid patients who have dual coverage.

Response: To ensure payment accuracy and program integrity, the 2008 DSH final rule and associated guidance clarified that all costs and revenues associated with Medicaid eligibles that have a source of private insurance coverage, including all third party payer revenues received by the hospital on behalf of the patient, must be included in the calculation of the hospital-specific DSH limit. Before this policy clarification, some states and hospitals were excluding costs and revenues, or simply revenues, associated with Medicaid eligible individuals with an additional source of coverage, such as Medicare or private insurance, when calculating hospital-specific DSH limits. This practice led to the artificial inflation of hospital-specific DSH limits and permitted

some hospitals to be paid twice based on the same costs. The clarifying policy included in the 2008 DSH final rule and associated guidance promotes fiscal integrity by preventing duplicate payment to DSH hospitals. It also promotes program integrity by ensuring that hospitals receive Medicaid DSH payments only up to the uncompensated costs incurred in providing inpatient and outpatient hospital services to Medicaid individuals or individuals with no health insurance or other source of third party coverage.

#### Scope of Inpatient and Outpatient Hospital Services

To be considered as an inpatient or outpatient hospital service for purposes of Medicaid DSH, a service must meet the federal and state definitions of an inpatient hospital service or outpatient hospital service and must be included in the state's definition of an inpatient hospital or outpatient hospital service under the approved state plan. Comments and our response to comments on the scope of inpatient and outpatient hospital services are as follows:

Comment: Several commenters requested clarification on the scope of Medicaid inpatient and outpatient hospital services. Specifically, they requested CMS to confirm that it did not intend to narrow the scope of these services for DSH purposes from what is considered allowable under the Medicaid program section 1905(a) of the Act.

Response: Within broad federal parameters, each state is responsible under §§440.10 and 440.20 for defining the amount, duration, and scope of inpatient or outpatient hospital services. This final rule does not affect the ability for states to define the scope of inpatient or outpatient hospital services. For Medicaid eligible or uninsured individuals, all costs incurred in providing inpatient hospital and outpatient hospital services identified in section 1905 of the Act and covered under the approved Medicaid state plan should be included when calculating the hospital-specific DSH limit.

Comment: A few commenters requested that CMS confirm that uninsured costs of hospital-based outpatient departments and clinics are to be included in the calculation of uncompensated care costs, irrespective of whether the hospital department or clinic is a federal



qualified health care (FQHC) for Medicaid payment purposes.

Response: Services that could be included in more than one benefit category must be treated consistently for payment purposes, since the payment methodologies are different for each benefit category. In particular, if a hospital elects to have a department meet the conditions to participate in Medicaid as a provider of FQHC services, and claims payment for its services as an FQHC, the services of that department are not considered outpatient hospital services. Although the FQHC may be provider based, its services are not recognized or paid as outpatient hospital services, but instead are covered and paid for as an FQHC service under section 1905(a)(2)(C) of the Act. Section 1923(g) of the Act only permits costs and revenues associated with services furnished as inpatient hospital and outpatient hospital services to be included when calculating the hospital-specific DSH limit. Congress provided for a different, cost-based, payment methodology for FQHCs, under sections 1902(a)(15) and 1902(bb) of the Act and did not provide for DSH payments as part of that methodology. In sum, states cannot include costs and revenues associated with FQHC services because payment for the services is authorized under a statutory benefit separate and distinct from outpatient hospital services that entitles the provider to a cost-based payment rate.

Comment: A few commenters noted the preamble in the proposed rule provided examples of hospital services that would have been prohibited from the hospital-specific DSH limit calculation based on the individual-specific approach set forth in the 2008 DSH final rule, but would be permissible under the service-specific approach in the 2012 DSH proposed rule. The examples make reference to medically necessary hospital services furnished to individuals who did not have coverage for those specific services. Commenters requested CMS to clarify if hospitals had to verify with Medicaid that services to uninsured individuals meet Medicaid protocols, such as prior authorization, and medical necessity reviews.

Response: Hospitals do not need to verify with Medicaid that services to uninsured individuals meet Medicaid protocols, such as prior authorization and medical necessity reviews.

To the extent that there is a non-Medicaid third party payer that covers the service for the individual subject to reasonable conditions, we expect the hospital to take appropriate steps to ensure that the individual can take advantage of that coverage. Thus, we do not expect that hospitals will claim as uncompensated care services for which an insurer would have paid if the hospital had followed appropriate protocols. To the extent that a hospital systematically fails to follow those protocols, there could be an issue for state regulatory authorities.

Comment: Several commenters requested CMS to clarify statements in the preamble of the 2012 DSH proposed rule regarding the requirement that the definition of inpatient and outpatient hospital services for DSH purposes must be consistent with federal and state regulations and be included in a Medicaid state plan. With respect to being included in the state plan, several commenters noted possible scenarios where care and services may be available in an inpatient or outpatient basis, but the state plan might not cover the treatment at all, or might exclude it because the Medicaid individual had exceeded limits on amount or duration. Commenters cited transplants as a service that might not be available under a particular state's Medicaid program, but fits within the federal definition of a Medicaid inpatient hospital service.

Response: For Medicaid eligible or uninsured individuals, only costs incurred in providing inpatient hospital and outpatient hospital services identified in section 1905 of the Act and that would meet the definition under the approved Medicaid state plan as inpatient hospital or outpatient hospital services should be included when calculating the hospital-specific DSH limit. Any services that fall outside of either definition are not eligible for inclusion in the calculation of the hospital-specific limit. For example, if transplant services are not covered under the approved state plan in a particular state, costs associated with those services cannot be included in calculating the hospital-specific DSH limit. In another example, a hospital might own and operate a nursing facility or a home health agency, employ physicians or other licensed practitioners, and bill for their professional services. While a hospital may have a connection to these services, they are not recognized as inpatient or outpatient hospital services and are not covered under the

inpatient hospital or outpatient hospital Medicaid benefit service categories. Accordingly, the associated costs and revenues cannot be included in calculating the hospital-specific DSH limit.

Services may be included in the DSH calculation if they are within the scope of the definition of inpatient or outpatient hospital services even if they are not covered under Medicaid because of amount or durational limits. States may establish reasonable limits on inpatient and outpatient services to ensure medical necessity or control utilization of services. Inpatient or outpatient hospital services furnished beyond state established limits on amount and duration may be included in the hospital-specific limit calculation to the extent that the services being sought are hospital services that the state Medicaid program would otherwise pay for if not for the limits being exceeded.

Comment: Several commenters requested clarification of swing bed services and stated that because these services are categorically inpatient in nature they should be included in a the calculation of the hospital-specific DSH limit.

Response: The commenters are referring to hospitals that have agreements to swing their acute hospital beds to long term care services in accordance with section 1913 of the Act. It is unclear if the commenters are referring to inpatient hospital care services or less acute nursing facility care services. The inpatient hospital care services must be included when calculating the hospital-specific DSH limit. The long term care services; however, are not inpatient hospital or outpatient hospital services and are covered under the nursing facility services benefit for Medicaid or skilled nursing facilities (SNF) benefit for Medicare. Therefore, these levels of services cannot be included in the calculation of the hospital-specific DSH limit.

Comment: A commenter requested clarification of whether days of care provided while patients are waiting to be discharged due to lack of appropriate setting can be included in the calculation of the hospital-specific DSH limit.

Response: Under Medicaid, these inpatient days are commonly referred to as inappropriate level of care days or administratively necessary care days. These days of care are

recognized as inpatient hospital services under section 1905(a) of the Act and are explicitly acknowledged in section 1923(b) of the Act that requires these days to be included in the DSH eligibility formula.

### C. Timing of Service Specific Determination

We specified in the proposed rule the determination of an individual's status as having a source of third party coverage can occur only once per individual per service provided and applies to the entire service, including all elements as that service, or similar services, would be defined in Medicaid. Comments and our response to comments on the timing of service specific determination are as follows:

Comment: Many commenters suggested that it would be appropriate to allow for redeterminations during a stay when coverage benefits are exhausted during a hospital stay. Commenters suggested various scenarios. For example, a patient with private insurance coverage is admitted to a hospital for treatment and 10 days following admission they reach their lifetime maximum coverage limit, but remain in the hospital for a total of 20 days. The commenters stated that a single determination would produce inequitable results. The commenters recommended that the patient should be considered uninsured for the remaining portion of their treatment after coverage limits are reached or exhausted during a hospital stay.

Response: We are finalizing the provision of the proposed rule that the determination of an individual's status as having a source of third party coverage can occur only once per individual per service provided and applies to the entire service, including all elements as that service, or similar services, would be defined in Medicaid. When benefits have been exhausted for individuals with a source a third party coverage, only costs associated with separate services provided after the exhaustion of covered benefits are permitted for inclusion in the calculation of the hospital-specific DSH limit. Section 1923(g) of the Act specifies that only certain costs associated with "individuals who are eligible for medical assistance under the state plan or who have no health insurance (or other source of third party coverage) for the services furnished during

the year” are included when calculating the hospital-specific DSH limit. Even if the third party coverage is exhausted or otherwise limited for a particular service, the individual still has a source of third party coverage for that particular service. Therefore, we are finalizing the single service determination as proposed.

Comment: Many commenters suggested allowing revisions to an individual’s insurance status during an inpatient hospital stay as necessary based on additional information received regarding the individual’s coverage. The commenters noted that the coverage determination usually occurs at intake, then new information may be obtained that warrants a change from the initial determination, (for example, a patient is retroactively determined eligible for Medicaid, or the patient’s third party insurance coverage has expired or has been exhausted).

Response: We do not think the single coverage determination precludes corrections to the initial determination. When a hospital classifies an individual as uninsured at intake, then later determines that the individual had Medicaid or third party coverage for that particular service, we would expect the hospital to re-classify the individual for purposes of calculating the hospital-specific DSH limit. Any individuals that have a source of third party coverage for a particular service, even if that coverage is limited, are considered for Medicaid DSH purposes to have a source of third party coverage even if their initial determination at intake is uninsured.

Comment: Several commenters expressed concern that a service-specific coverage determination for each service rendered to each individual with third party liability could be unduly burdensome to hospitals, contracted DSH auditors and states. Commenters stated that CMS should issue clear instructions regarding acceptable implementation of this requirement, the level of detail of claims, and patient data needed.

Response: We will work with states to ensure that all stakeholders receive clear federal and state guidance regarding service-specific coverage determinations. In general, it would be to the advantage of hospitals to engage in service-specific coverage determinations because it would result in more documented uncompensated care costs.

Comment: One commenter recommended that CMS increase accountability and improve patient access to financial assistance by directing funding to states that condition hospital payments on provision of financial assistance to needy patients.

Response: The comments are outside the scope of the proposed and final rule. Section 1923(c) of the Act provides states with considerable flexibility in establishing DSH payment methodologies as long as the DSH payments under the methodology do not exceed the state's federal DSH allotment and the hospital-specific DSH limit.

#### Co-Insurance, Co-Pays, and Deductibles

Section 1923(g) of the Act excludes costs associated with individuals with a source of third party coverage for a service from the calculation of the hospital-specific DSH limit. In the 2012 DSH proposed rule, we stated that costs associated with unpaid coinsurance, deductibles, bad debts, and payer discounts for individuals with a source of third party coverage are excluded when calculating the hospital-specific DSH limit. In the proposed rule, we reiterated this statement and are finalizing those provisions as proposed without change. Comments and our response to comments regarding co-insurance, co-pays, and deductibles are as follows:

Comment: A commenter requested clarification regarding how Medicaid programs should treat out-of-pocket costs relating to an inpatient stay. The commenter provided an example where a patient is admitted for an inpatient stay and his or her insurance does not provide any payment for the first 5 days of the stay. The insurance plan requires that the patient pay out-of-pocket until day six. The commenter requested clarification regarding the treatment of the first 5 days for purposes of calculating the hospital-specific DSH limit, including cases where the payment exclusion is due to an individual's pre-existing condition.

Response: When an individual has a source of third party coverage for an inpatient or outpatient hospital service, the costs and revenues cannot be included in the calculation of the hospital-specific limit unless the individual is also Medicaid eligible. In the commenter's example, to the extent that the individual has a source of coverage for the specific inpatient

hospital service, it could not be included in the calculation of the hospital-specific limit. Any uncompensated costs that hospitals incur for unpaid co-pays, co-insurance, or deductibles associated with a non-Medicaid eligible individual who has insurance cannot be included in the calculation of the hospital-specific limit. Exclusions relating to pre-existing conditions would depend on the terms and nature of the exclusion. If the exclusion bars coverage for particular services, the person would be considered uninsured. When the exclusion results in a higher deductible or cost sharing for services related to the preexisting condition, the person would be considered insured.

Comment: Many commenters stated that patients with a high-deductible plan/catastrophic plan should be considered uninsured for services until they meet their deductible or spending thresholds. The commenters stated that hospitals are bearing the burden of unreimbursed costs associated with high deductible amounts or catastrophic health plans where the individual has no means of paying the deductible amounts. Additionally, commenters noted that the unpaid deductible and copayments are the fastest growing part of uncompensated care costs and requested CMS to expand the definition of uninsured to include the underinsured costs associated with unpaid copayments and deductible in the hospital DSH limits.

Response: We acknowledge concerns regarding the financial challenges that hospitals may encounter in providing services to individuals with high deductible or catastrophic coverage health plans. Section 1923(g) of the Act restricts the calculation of DSH-eligible uncompensated costs to those incurred in providing inpatient and outpatient hospital services to Medicaid-eligible individuals and those individuals with no source of third party coverage for the services they receive. When an individual's policy includes in its benefit package inpatient or outpatient hospital services obtained by the individual, we consider this person to have a source of third party coverage for services included in the benefit package unless the individual has exhausted insurance coverage prior to the service at issue. When benefits have been exhausted for individuals with a source a third party coverage, only costs associated with separate services

provided after the exhaustion of covered benefits are permitted for inclusion in the calculation of the hospital-specific DSH limit. The individual is considered insured for the service even in instances when the policy requires the individual to satisfy a deductible and/or share in the overall cost of the hospital service.

Comment: Several commenters stated that individuals whose only source of coverage is a limited benefit plan should be treated as uninsured for purposes of the DSH limit calculation. For example, if a patient has an extended stay in a hospital trauma center after a car accident, and the patient's only coverage is through limited medical care payment under an auto insurance plan (a per accident amount), the hospital should be able to include as uncompensated cost the significant services provided once the per accident limitation is exceeded. The commenter asserts that these plans are not health plans or health insurers, and the medical benefits they afford are incidental to the principal insurance benefits. These types of policies are defined as "excepted benefits" under the Health Insurance Portability and Accountability Act regulations at §148.220. In some cases, the legal liable third party may not be determined until years after the services were provided because the liability of these third parties is not established for specific services. A hospital's entitlement may not be certain until after legal proceedings or negotiations. Individuals, in these situations should be treated as uninsured for the costs of services provided offset by the amount of any payment actually received by the hospital from a legally liable third party.

Response: We have previously considered limited benefit plans and issued our position in the 2008 DSH final rule. In that final rule, we provided that these plans, such as auto insurance, would not be considered insurance except when they are legally liable to pay for hospital care. The change to a service-specific approach does not affect our previous guidance.

The 2008 final DSH rule and related CMS guidance addressed the treatment of revenue offsets that must be applied against the cost of providing services to individuals with no source of third party coverage. The guidance addressed future revenue streams including, but not limited to, legal decisions, payment plans, and recoveries. The General DSH Audit and Reporting Protocol



specified that that states, hospitals, and auditors, for purposes of individuals with no source of third party coverage, should not attempt to allocate payments received during the State plan rate year to services provided in prior periods. It, instead, required that all payments received in the year will be counted as revenue to the hospital in that same year. It was understood that some costs incurred during the state plan rate year under audit may be associated with future revenue streams (legal decisions, payment plans, and recoveries), but that the payments must not counted as revenue until actually received.

When a hospital classifies an individual as uninsured at intake, then later determines that the individual had Medicaid or third party coverage for that particular service, we expect the hospital to re-classify the individual for purposes of calculating the hospital-specific DSH limit. Any individuals that have a source of third party coverage for a particular service, including limited coverage, are considered for Medicaid DSH purposes to have a source of third party coverage even if their initial determination at intake is uninsured. We recognize that corrections to the initial determination may be warranted based on information available only after the completion of the DSH audit and reports for a particular state plan rate year. In these instances, states are not required to correct the audit for the closed period to reclassify the individual. However, for individuals, states must still offset all associated revenues received by the third party payer against costs incurred for the uninsured in the year in which the revenue is received. If cumulative correcting adjustments would be significant on a state-wide basis due to a series of warranted corrections that arise post-audit (for example, widespread errors in individual coverage determinations), states should correct the audit and report by indicating post-audit adjustments and must reopen the audit to make a correction.

Comment: A commenter recommended that costs associated with unpaid co-insurance, deductibles, and payer discounts that qualify as charity care be permitted in the calculation of the hospital-specific limit. The instructions for Form CMS 2552-10, Worksheet S-10 Hospital Uncompensated and Indigent Care Data specifically states that deductible and coinsurance

payments for patients who are covered by public or private insurers, which the provider has a contractual relationship and are approved for charity care be included on line 20, column 2. The commenter believes that these instructions should be consistent for both the hospital-specific DSH limit calculation and the Medicare Form 2552-10, Worksheet S-10.

Response: Medicare and Medicaid are separate programs and the statutory framework for each program is different. Costs that may be relevant for Medicare purposes, such as bad debt or charity care, are not relevant to Medicaid DSH. These costs are relevant to Medicare payment mechanisms that ensure that the Medicare program does not shift costs onto other payers, which do not apply in the Medicaid program. Section 112(b) of the Balance Budget Refinement Act (BBRA) requires that Medicare-participating hospitals submit in their Medicare cost reports data on costs incurred by a hospital for providing inpatient and outpatient hospital services for which no compensation is received. This provision specifically requires hospitals to include data on non-Medicare bad debt, charity care, and charges for Medicaid and indigent care. While there may be overlaps between these costs as reported in Medicare cost reports and the costs considered under the Medicaid hospital-specific DSH limit at section 1923(g) of the Act, the Medicare reporting requirement is different and broader than the Medicaid hospital-specific DSH limit at section 1923(g) of the Act. Thus, the same data cannot be used for both purposes.

Comment: A number of commenters stated bad debt and payer discounts should be included in the Hospital DSH limit.

Response: As defined in the DSH audit reporting requirement in regulations at §447.299(c)(15), uncompensated care costs for inpatient and outpatient hospital services does not include bad debt or payer discounts related to services furnished to individuals who have health insurance or another third party payer.

#### D. Physician Services

The hospital-specific DSH limit established in section 1923(g) of the Act permits the inclusion of inpatient and outpatient hospitals service costs only. Services that are not inpatient or

outpatient hospital services, including physician services, must be excluded when calculating the hospital-specific DSH limit. Comments and our response to comments regarding physician services are as follows:

Comment: Many commenters requested that unreimbursed physician costs associated with hospital services should be included in the hospital DSH limit calculation. Two common requests were that states be permitted to define their inpatient and outpatient hospital benefits services of physicians employed by the hospital. The commenters stated that since the costs of physicians furnishing services to the hospital are already allowable, they interpret this to refer to direct patient care furnished by physicians. Additionally, commenters stated that CMS could allow a hospital to include the cost of its salaried physicians in its DSH costs as long as those salaries were not greater than what is allowed under the Medicare program. Commenters believe if the hospitals do not separately bill for physician services then the costs hospitals incur to secure physician services to serve a hospital's Medicaid population are legitimate costs.

Response: Section 1905(a) of the Act identifies categories of medical items and services eligible for federal matching payment under the Medicaid program. Inpatient hospital services, outpatient hospital services, and physician services are listed as separate and distinct categories of Medical assistance. Inpatient hospital services are defined in section 1905(a)(1) of the Act and implementing regulations at §440.10, outpatient hospital services are defined at section 1905(a)(2)(A) of the Act and implementing regulations at §440.20(a), and physician services are defined at section 1905(a)(5)(A) of the Act and implementing regulations at §440.50(a).

The DSH limit provided in section 1923(g) of the Act, refers only to hospital services and does not include physician services or any other Medicaid services listed in section 1905(a) of the Act. Furthermore, state DSH payments are made pursuant to section 1902(a)(13)(A)(iv) of the Act as part of state payment rates set for inpatient hospital services to take into account the situation of hospitals that serve a disproportionate share of low-income patients with special health needs. Section 1923(a)(1)(B) of the Act requires states in paying for inpatient hospital services, to

increase payments to the hospitals consistent with the minimum DSH payment requirements set forth in section 1923(c) of the Act. While the term “hospital services” does expand DSH beyond just inpatient hospital services, this expansion is not unlimited, and the legislative history shows that the term is limited to include only outpatient hospital services.

The distinction between physician services, inpatient and outpatient services is a long standing position and recognized throughout the Medicaid program as well as other insurance programs and hospital accounting practices. The Medicaid program has special requirements that are unique to each service type. Hospital services are subject to public process requirement in section 1902(a)(13)(A) of the Act and as previously mentioned, rates set under that process must include payment adjustment for DSH providers that comply with the requirement in section 1923 of the Act. Medicaid inpatient and outpatient hospital services are also subject to additional payment requirements known as Medicaid upper limits (UPLs) in regulations at §447.272 and §447.321, with inpatient hospital service also being limited to customary charges pursuant to section 1903(i)(3) of the Act and regulations at §447.271. Unlike hospital services, Medicaid physician services are subject to the general public notice requirements at §447.205, Medicaid economy, efficiency, and quality of care requirements, but not subject to any specific regulatory UPL requirements. With respect to primary care physician services are eligible for higher federal matching rate.

As we explained in the preamble of the 2008 DSH final rule, physician professional services are generally not recognized or considered hospital service costs reporting process under either Medicaid or Medicare. Physician services cost identified as professional services are removed from the inpatient and outpatient hospital costs as part of the hospital cost step down process. The Medicare 2552 cost report does not include direct physician patient care services. These costs are identified, segregated, and are paid not as a hospital services but separately as professional services in accordance with a fee schedule established for physician services. Therefore, any physician costs attributable to professional services that are reimbursed as

physician services under a state's Medicaid program, are not allowable in the DSH limit calculation, since by statute, the DSH limit can include only inpatient and outpatient hospital services.

The general rule is that physician services that are covered and reimbursed as such under a state's Medicaid program are excluded from the DSH limit calculation. We realize in some instances, some states may set a single rate for an inpatient or outpatient hospital service and included in the rate is the costs of physician services. A hypothetical example might be a single per diem rate for a day of inpatient care, with no separate payment for physician services to a hospital or physician. In that instance, the physician cannot bill the patient or the Medicaid program for their professional services since it is already included in the per diem rate paid to the hospital. We do not feel this is the customary practice, but where this practice is used, the entire bundle of services included in the per diem hospital payment rate, including any physician and practitioner services, would be considered part of the inpatient or outpatient hospital services.

Comment: A commenter noted that exclusion of physician uncompensated care costs in the DSH limit calculation has had a detrimental financial impact on children's hospitals and fails to recognize the increasingly important role of hospital based physicians in guaranteeing Medicaid and low-income children access to primary and specialty care. Commenters stated data indicates that hospitals now employ approximately 25 percent of all active physicians, and these employment relationships are expected to increase as more integrated care models enter the market place. Therefore, they believe it is critical for CMS to recognize the safety net role of children hospital and the financial losses that hospitals absorb should be eligible for inclusion in the hospital-specific DSH limit under section 1923(g) definition because they represent losses incurred by a DSH eligible hospital for services to Medicaid beneficiaries.

Response: We appreciate and value the contribution children's hospitals, the physicians they employ to assure Medicaid, and other low income children have access to needed care and services. While the Medicaid statute does not contemplate DSH payments beyond inpatient

hospital services that exceed the uncompensated care cost incurred for inpatient and outpatient hospital services furnished to Medicaid and uninsured individuals, states have the option to increase Medicaid payments rate for physician services for services furnished in children's hospital settings. Physician payment rates are not subject to the same limitations as payments to hospital services.

Comment: A few commenters stated many safety net hospitals, particularly those located in inner-cities and rural areas, employ physicians in order to provide access to critical hospital inpatient and outpatient services for their communities. The commenters stated that the costs associated with employing physicians are legitimate hospital costs and should be included in the calculations of the hospital-specific DSH limitations. These commenters stated that excluding these costs from this calculation only further threatens the tenuous financial status of safety net hospitals and their ability to maintain services for underserved populations.

Response: We value and appreciate all health care providers that participate in the Medicaid program to make health care available in the communities they serve. Hospital services and physician services are separate and distinct services. The DSH limit in section 1923(g) of the Act is specific to only hospital services. Physician professional services recognized, billed, or paid as such under a state's Medicaid program are not allowable costs for purposes of Medicaid DSH. To the extent that states wish to provide incentives for physicians to work in underserved areas, states have the option to target adjustments to physician payment rates.

Comment: A commenter stated that it appears CMS has approved waivers in two states that allow state Medicaid programs to reimburse hospitals for hospital-based physician costs. These costs associated with securing physician services to serve a hospital's Medicaid population are legitimate unreimbursed costs if the hospital does not separately bill for the services. The waivers seem to instruct that both costs and payments be excluded from DSH audits. If this is the case, this option would achieve the same result and could be considered by CMS as an alternative for the DSH limit calculation.

Response: We believe the commenter may be referring to Section 1115 waivers. Section 1115 of the Act gives the Secretary of Health and Human Services (the Secretary) authority to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and Children's Health Insurance Program (CHIP) programs. The purpose of these demonstrations, give states additional flexibility to design and improve their programs, to demonstrate and evaluate policy approaches such as:

- Expanding eligibility to individuals who are not otherwise Medicaid or CHIP eligible.
- Providing services not typically covered by Medicaid.
- Using innovative service delivery systems that improve care, increase efficiency, and reduce costs.

In general, the section 1115 demonstrations are approved for a five-year period and can be renewed, typically for an additional 3 years. The demonstrations must be “budget neutral” to the federal government, which means that during the course of the project federal Medicaid expenditures will not be more than federal spending could have been without the use of 1115 waiver authority. Several states have requested and have approved section 1115 demonstration proposals that, in part, allow the state to use savings generated by the overall demonstration project for payments to hospitals for unreimbursed physician costs provided by hospital employees or contractors. For DSH purposes, these are considered to be payment for physician services and; therefore, neither the costs nor payments related to physician services are included in the DSH limit calculation.

#### E. Prisoners

The preamble to the proposed rule clarified that the proposed change in the definition of uninsured would not have any impact on how prisoners are treated in the DSH limit calculation. The DSH limit includes hospital services to individuals who are Medicaid eligible or who have no health insurance. Current DSH inmate guidance issued to states in a letter dated August 8, 2002, addressed only the uninsured possibility, and clarified that prisoners would not qualify for DSH

under that authority. That guidance stated that since the federal, state, or local agencies that hold individuals in custody are responsible to cover their basic needs (including medical needs), they are legally liable for medical care and are a source of third party coverage.

The preamble discussion may have created some unnecessary confusion because it did not address Medicaid eligible inmates. We received many comments pointing to prior CMS guidance related to inmate and eligibility Medical Assistance. Medicaid generally does not pay for medical care and services to inmates. This is known as the inmate of a public institution exclusion. This exclusion is not absolute as there is an exception regarding patients in a medical institution. Pursuant to Medicaid policy set forth in a 1997 letter to all state Medicaid Directors, we interpreted this exception to allow Medicaid to pay for inpatient care furnished to inmates that have been determined to be eligible for Medicaid under a state's program. In adopting the service specific definition of uninsured, we did not mean to suggest a change in long standing inmate policy under the regular program. With respect to DSH, in those cases in which a Medicaid eligible individual meets the patient in a medical institution exception – (that is, a Medicaid eligible inmate is transferred to a hospital to be a patient for inpatient services), the state Medicaid agency has determined the individual to be eligible for Medicaid, and makes a regular hospital payment, DSH can be used to make up any shortfall. The costs of the service less non-DSH payments would be factored into the limit calculation. (Services received or costs incurred as a patient in a prison hospital, or in a dedicated prison ward, cannot be included in the calculation of the hospital-specific DSH limit since these entities could not meet the hospital conditions of participation related to patient rights.) The exception to the exclusion is limited to inpatient services, so any outpatient services obtained by an inmate would not be reimbursable under regular Medicaid or could not be included in the calculation of DSH.

Comment: Many commenters suggested CMS not to change current non-DSH Medicaid inmate policy. We also received many inquiries related to Medicaid eligibility related to inmates.

Response: We agree eligibility for Medicaid and inmates is a separate policy area outside



of the DSH program. In this final rule we are not making any changes to current Medicaid non-DSH inmate policy and we are not addressing specific inquiries related to that policy because it is outside the scope of this rule.

#### F. Indian Health Services

In the 2012 DSH proposed rule, we specified that, for Medicaid DSH purposes, American Indians/Alaska Natives are considered to have third party coverage for inpatient and outpatient hospital services received directly from IHS or tribal health programs (direct health care services) and for services specifically authorized under CHS. The service-specific determination of third party coverage status of American Indian/Alaska Natives for services not authorized to be within the scope of coverage by CHS should be made in the same way as all other patients. This is the same treatment that we apply to services that are outside the scope of coverage from any other insurer or third party payer. Comments and our response to comments regarding Indian Health Services are as follows:

Comment: Many commenters stated that the regulation should allow hospitals to count unfunded and unreimbursed costs attributed to IHS facilities, tribal program, and contract health services toward the hospital-specific DSH limit. Commenters recommended that any subsequent cash settlement should be treated as a cash collection from the uninsured in the ensuing DSH audit cycle. Another commenter expressed concern that when Indian Health Care Providers render services to IHS-eligible persons the uncompensated costs associated with the service could not be included in calculating the hospital-specific DSH limit.

Response: The determining factor in deciding whether an American Indian or Alaska Native has health insurance for an inpatient or outpatient hospital service is if the providing entity is an IHS facility or tribal health program. In the case of contract services, the coverage of the services is specifically authorized via a purchase order or equivalent document because individuals in these circumstances are considered to have a source of third party payment. The cost of services and any revenues received would be excluded from the DSH calculation. Individuals

obtaining inpatient or outpatient hospital services from a non-IHS or tribal facility without a purchase order (or other authorization) would be considered uninsured for these services. The costs of these services and revenues received could be included in the DSH limit calculation.

Comment: A few commenters stated hospitals participate in the CHS program through a formal arrangement that includes a purchase order or its equivalent. A strict reading of the regulatory language suggest that hospitals' formal arrangements with the CHS program would disqualify those unreimbursed costs as eligible to be counted for purposes of calculating the DSH limit. The commenters requested that CMS clarify that these unfunded services would be eligible for costs.

Response: An American Indian or Alaska Native would be considered to have no health insurance when he or she obtains services without a purchase order or equivalent authorization to pay for them. If contract providers have provided needed services that were not pursuant to a purchase order, the American Indian or Alaska Native would be considered uninsured (absent private coverage) and the costs and any revenues associated with these services could be included in the limit.

Comment: A commenter indicated that CMS did not engage in tribal consultation on the 2012 DSH proposed rule as required under section 5006(e) of the American Recovery and Reinvestment Act or Executive Order 13174, "Consultation with Tribal Governments." Therefore, CMS should engage in consultation with the American Indians and Alaska Native tribes before issuing a final rule.

Response: We solicited input on the proposed rule from IHS, Tribal, and urban programs on March 16, 2012 during an All Tribes' Call. The purpose of the call was to solicit input regarding how implementation or changes to regulatory provisions would affect American Indians and Alaska Native beneficiaries and the operation of the Indian health program delivery system.

Comment: A commenter, recognizing that the statute only addresses "a State or local unit of government within a State," recommends that CMS include a provision in the final regulation

that would treat IHS and tribal hospitals similarly to “a State or unit of local government within a State” for purposes of section 1923(g)(1)(A) of the Act.

Response: The comments are outside the scope of the proposed and final rule.

Comment: A few commenters expressed concern regarding the proposed rule’s reliance on the definition of creditable coverage under 45 CFR Parts 144 and 146.

Response: In this final rule, we are defining “individuals who have no health insurance (or other source of third party coverage) for the services furnished during the year” for purposes of calculating the hospital-specific DSH limit on a service-specific basis rather than on an individual basis, and thus do not make reference to the regulatory definition of creditable coverage. The definition instead requires a determination of whether, for each specific service furnished during the year, the individual has third party coverage.

#### G. Affordable Care Act

In response to the 2012 DSH proposed rule, we received a number of comments requesting clarification regarding how this final rule interacts with the Affordable Care Act. Comments and our response to comments on the Affordable Care Act are as follows:

Comment: A commenter stated that CMS should issue guidance on the definition of uninsured addressing issues that may be raised by the changes to the health insurance landscape when the remaining Affordable Care Act reforms take effect in 2014, including implementation of state Health Insurance Exchanges and individual mandates. After the implementation of state-based exchanges in 2014, the definition of uninsured should include people who do not qualify for exchange-based coverage because of immigration status; people who receive an affordability waiver of the individual mandate; patients with coverage that meets the essential health benefits standards or catastrophic plan requirements but does not cover a provided service, and other uninsured consumers.

Response: Absent a legislative change to the DSH law, we believe the determination of uninsured status will continue to be a fact-based determination that occurs at the time a patient

presents to a hospital. Undoubtedly, some or all of the individuals in the populations the commenters cited would be considered uninsured when presenting to the hospital.

Comment: A commenter stated that, with the reduction in DSH dollars in accordance with the Affordable Care Act, it is critical to require that hospitals collect information for each patient to determine their status as uninsured. The commenter stated that these issues should be addressed in the proposed rule implementing provisions of the Affordable Care Act requiring a reduction to DSH allotments. The commenter recommended various reporting activities, to ensure DSH funds are used to pay for the uninsured.

Response: The comments are outside the scope of this regulation.

#### H. DSH Audit Oversight

Comment: Several commenters provided inquiries related to the DSH Audit and Reports that are required by section 1923(j) of the Act and implemented in regulations Parts 447 and 455. The commenters generally requested greater CMS oversight to the Medicaid DSH audit program, clearer guidance, better communication between state programs, auditors, and hospitals, or highlighted other programmatic concerns related to the audits.

Response: While the methods and procedures related to state reports and audits is outside the scope of this regulation, we will continue to provide technical assistance and guidance to states to assure compliance with section 1923(j) of the Act.

Comment: Several commenters stated that CMS should conduct ongoing evaluation of how DSH funds are distributed within a state and how funds are used by states and hospitals to adequately address the needs of remaining uninsured patients. Commenters stated that it will be critical to ensure the diminishing uncompensated care funding like DSH, and related policies, is properly targeted and allocated to those providers who continue to serve the uninsured.

Response: States are required under section 1923(j) of the Act to report information about their DSH program and have it independently audited. We will continue to review this information.

### **III. Provisions of the Final Rule**

#### **A. Definition of Uninsured under Section 1923(g) of the Act**

We are finalizing with one clarifying change to the provisions in the 2012 DSH proposed rule. Specifically, we have revised the regulations text to clarify the definition of “health care coverage limit” to include other coverage limits than annual and lifetime limits. We are adding a new §447.295 Hospital-Specific Disproportionate Share Hospital Payment Limit - Definition of Individuals Who Have no Health Insurance (or Other Source of Third Party Coverage) for the Services Furnished During the Year and the Determination of an Individual’s Third Party Coverage Status. Specifically, §447.295(a) describes the scope of the new regulatory section and its focus on defining the term “individuals who have no health insurance (or other source of third party coverage) for the services furnished during the year.”

Section 447.295(b) defines through regulation “individuals who have no health insurance (or other source of third party coverage) for the services furnished during the year” for purposes of calculating the hospital-specific DSH limit as described in section 1923(g) of the Act effective for 2011. Section 447.295(b) also provides specific definitions for the terms “service-specific coverage determination” and “health insurance coverage limit.”

In this final rule, we are defining “individuals who have no health insurance (or other source of third party coverage) for the services furnished during the year” for purposes of calculating the hospital-specific DSH limit on a service-specific basis rather than on an individual basis, and thus do not make reference to the regulatory definition of creditable coverage. The definition instead requires a determination of whether, for each specific service furnished during the year, the individual has third party coverage.

We are also implementing the definition of “no source of third party coverage for a specific inpatient or outpatient service” to mean that the service is not within a covered benefit package under a group health plan or health insurance coverage (including the Medicare program), and is not covered by another legally liable third party. We are specifying that services beyond

health coverage limits on insurance coverage, including annual or lifetime limits, will not be considered to be within a covered benefit package.

Because funding limitations for services furnished through the IHS or tribal health programs are similar in nature to benefit limitations, we consider them as such for this purpose. This final rule considers services furnished to American Indians/Alaska Natives to be covered by IHS or tribal health programs only to the extent that the individuals receive services directly from IHS or tribal health programs (direct health care services) or when IHS or a tribal health program has authorized coverage through the contract health service program (through a purchase order or equivalent document).

We are not including in this final rule a single test for how a “service” is defined for these purposes because of the variance in the types of services that are at issue. However, we are including at §447.295(c)(1) “Determination of an Individual’s Third Party Coverage Status,” the principle that a “service” should include the same elements that would be included for the same or similar services under Medicaid generally. The intent is that the hospital will generally determine that an individual is either insured or not insured for a given hospital stay, and will not separate out component parts of the hospital stay based on the level of payment received.

Section 447.295(c) specifies that the determination of an individual’s third party coverage status is a service-specific measure for purposes of calculating the hospital-specific DSH limit, based on the coverage and benefit exclusions of health insurers and the availability of coverage for that service from other third party carriers. This final rule establishes that the determination of an individual’s status as an “individual who has no health insurance (or other source of third party coverage)” for purposes of calculating the Medicaid hospital-specific DSH limit be based on coverage for the particular inpatient or outpatient hospital service provided to an individual under the terms of an insurance or other coverage plan, or actual coverage for the service through such a plan or another third party. The determination is not based on payment.

#### B. Lifetime Limits, Limited Coverage Plans, and Exhausted Benefits

This final rule clarifies the definition of “individuals who have no health insurance (or other source of third party coverage) for the services furnished during the year” so that inpatient and outpatient hospital costs associated with individuals who have third party coverage but have reached annual or lifetime insurance limits or have otherwise exhausted covered benefits can be included in calculating the hospital-specific DSH limit. For purposes of the preceding sentence, the only costs that are permitted for inclusion in the calculation of the limit are for separate services provided after the exhaustion of covered benefits. Additionally, inpatient and outpatient hospital costs of services provided to individuals whose coverage specifically excludes the hospital service provided can be included in calculating the hospital-specific DSH limit. This interpretation and definition of “uninsured” affords states and hospitals maximum flexibility permitted by statute in calculating the hospital-specific DSH limit. This clarification is effective for DSH audits and reports submitted following the effective date of the rule, thus avoiding any unintended, and potentially significant, financial impact resulting from the 2008 DSH final rule.

While this final rule provides some relief for certain costs by allowing their inclusion in the calculation of the hospital-specific DSH limit, we believe that it is equally important to address those costs that are currently prohibited from inclusion and for which this rule provides no change in treatment under title XIX of the Act. For the reasons described below, we continue to believe that currently prohibited costs are not appropriate for purposes of Medicaid DSH and are not consistent with statutory language with respect to the hospital-specific DSH limit.

#### C. Bad Debt and Unpaid Coinsurance and Deductibles

This final rule clarifies the definition of “individuals who have no health insurance (or other source of third party coverage) for the services furnished during the year” such that costs associated with bad debt, including any unpaid coinsurance and deductibles required under third party coverage, and payer discounts under such coverage cannot be included in calculating the hospital-specific DSH limit for individuals with a source of third party coverage. In these instances, the cost of the service in question was provided to an individual with a source of third

party coverage for the service, and the amount due represents uncollected revenues not uninsured costs. This clarification ensures that this final rule is consistent with existing DSH statute, regulations, and longstanding CMS policy.

Section 1923(g) of the Act requires that costs associated with individuals with a source of third party coverage be excluded from the calculation of the hospital-specific DSH limit. The current DSH regulations, as modified by the 2008 DSH final rule, also prohibit the inclusion of costs associated with unpaid coinsurance, deductibles, bad debt, and payer discounts for individuals with a source of third party coverage. This final rule makes no change to the allowability of these costs.

#### D. Prisoners

This final rule clarifies that the final definition of “individuals who have no health insurance (or other source of third party coverage) for the services furnished during the year” maintains the current position that individuals who are inmates in a public institution are considered to have a source of third party coverage as described in guidance issued to states in a letter dated August 8, 2002. The final rule does not make any changes to current Medicaid Non-DSH inmate policy.

#### E. Clarification of the Application of the Definition of “Individuals Who Have no Health Insurance (or other Source of Third Party Coverage) for the Services Furnished During the Year” for Purposes of Calculating Hospital-Specific DSH Limits.

Section 447.295(d) specifies that costs considered for purposes of calculating the hospital-specific limit are limited to net costs incurred for individuals who have no health insurance or source of third party coverage for the services furnished during the year. This section ensures that the regulatory definition of “individuals who have no health insurance (or other source of third party coverage) for the services furnished during the year” is appropriately applied for purposes of calculating hospital-specific DSH limits.

### **IV. Waiver of 60-Day Delay in the Effective Date**



We ordinarily provide a 60-day delay in the effective date of the provisions of a major rule, pursuant to 5 U.S.C. 801(a)(3). However, if we find, for good cause, that notice and public procedure are impracticable, unnecessary, or contrary to the public interest, and incorporates a statement of the finding and the reasons in the rule issued, the 60-day delay in the effective date can take effect as we determine in 5 U.S.C. 808(2).

We find good cause to provide a 30-day delayed effective date instead of a 60-day delayed effective date. Many states and hospitals continue to apply the pre-DSH audit transition period definition of “uninsured” articulated in the August 17, 1994 letter to State Medicaid Directors. This rule, effective for the first audits due after the DSH audit transition period, realigns the definition of “uninsured” with the pre-DSH audit transition period definition. We find that a 30-day delay in the effective date would be sufficient to permit implementation of this definition, and that additional time would be unnecessary, because this rule conforms the audit standards to the practice and procedure that many states and hospitals followed through the DSH audit transition period and are following now.

This rule ensures that audit standards for state DSH payments made to hospitals during the DSH audit transition period will not exceed the hospital-specific limit as a result of using the old definition.

## **V. Collection of Information Requirements**

This rule does not impose any new or revised reporting, recordkeeping, or third-party disclosure requirements. Additionally, it does not impact any auditing or reporting requirements/burden associated with section 1923(j) of the Act or information collections under the CMS-2552 (OMB control number 0938-0050) cost report. Consequently, the rule does not require additional review by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 et seq.).

## **VI. Regulatory Impact Analysis**

## A. Overall Impact

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

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). We do not have definitive national data that isolates the impact of this rule on hospital-specific DSH limits or national DSH payments. Due to the lack of this data we are unable to predict and estimate the impacts of this final rule, including those of individual hospitals or groups of hospitals. However, a rough calculation for one large hospital system indicates that that system alone would experience rule-induced transfer impacts of over \$100 million in the next year. As a result, this rule has been designated an “economically significant” rule under section 3(f)(1) of Executive Order 12866, since it may have an economic impact in excess of \$100 million. Furthermore, it is a major rule under the Congressional Review Act. Accordingly, we have prepared a Regulatory Impact Analysis (RIA) that, to the best of our ability, presents the costs and benefits of the rulemaking. In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

The RFA requires agencies to analyze options for regulatory relief of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of \$7.5 million to \$38.5 million in any 1 year. Individuals and States are not included in the definition of a small entity.

As its measure of significant economic impact on a substantial number of small entities, HHS uses a change in revenue of more than 3 to 5 percent. This rule affects the calculation of the hospital-specific DSH limit. States may reduce Medicaid DSH payments to certain providers and increase DSH payments to other providers as a result of changes to the hospital-specific DSH limit, so it is possible that this rule could result in a change of more than 3 to 5 percent of total hospital revenue due to the overall size of the Medicaid DSH program. Regardless, states alone are responsible in the management of their DSH allotment, retain the same flexibility to design DSH payment methodologies under the state plan, and are not required to increase or to decrease payments to providers as a result of this rule. Additionally, we do not have national data that isolates the impact of this rule on hospital-specific DSH limits or national DSH payments. Based on the lack of data and the factors described above, we cannot predict an accurate estimate of the impact on individual hospitals. As a result, this final rule may have a significant economic impact on a substantial number of small entities. This analysis, combined with the preamble, constitutes our final analysis for the RFA.

In addition, section 1102(b) of the Social Security Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area for Medicare payment regulations and has fewer than 100 beds. This rule affects the calculation of the hospital-specific DSH limit. States may reduce Medicaid DSH payments to certain providers and increase DSH payments to other providers as a result of changes to the hospital-specific DSH limit, so it is possible that this rule may have a significant impact on small rural hospitals due to the overall size of the Medicaid DSH program. Regardless, states alone are responsible for the management of their DSH allotment, retain the same flexibility to design DSH payment methodologies under the state plan, and are not required to increase or to decrease payments to providers as a result of this rule. Additionally, we

do not have national data that isolates the impact of this rule on hospital-specific DSH limits or national DSH payments. Based on the lack of data and the factors described above, we cannot predict an accurate estimate of the impact on small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of \$100 million in 1995 dollars, updated annually for inflation. In 2014, that threshold is approximately \$141 million. This rule has no consequential mandate on state, local, or tribal governments or on the private sector.

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

Pursuant to E.O. 13175 and the CMS Tribal Consultation Policy (November 2011), CMS consulted with Tribal officials prior to the formal promulgation of this regulation.

## B. Anticipated Effects

### 1. Effects on State Medicaid Programs

CMS does not anticipate that the final rule will have significant financial effects on State Medicaid Programs. Federal share DSH allotments, which are published by CMS in an annual **Federal Register** notice, limit the amount of Federal financial participation (FFP) that can be paid annually to a state for aggregate DSH payments made to hospitals. This final rule does not modify the DSH allotment amounts and will have no effect on a state's ability to claim FFP for DSH payments made up to the published DSH allotment amounts.

This final rule, however, may affect the calculation of the hospital-specific DSH limit established at section 1923(g) of the Act. This hospital-specific limit requires that Medicaid DSH payments to a qualifying hospital not exceed the costs incurred by that hospital for providing

inpatient and outpatient hospital services furnished during the year to Medicaid patients and individuals who have no health insurance or other source of third party coverage for the services provided during the year, less applicable revenues for those services. This final rule defines “individuals who have no health insurance (or other source of third party coverage) for the services furnished during the year” for purposes of calculating the hospital-specific DSH limit effective for 2011. This final rule also provides additional clarification to states and hospitals regarding costs eligible for inclusion in the calculation of the hospital-specific DSH limit. The provisions of this rule may have an effect on the calculation of the hospital’s specific DSH limit amount for some hospitals depending upon the method utilized by the hospital or state in calculating the limit prior to the effective date of the final rule.

States retain considerable flexibility in setting DSH State plan payment methodologies to the extent that these methodologies are consistent with section 1923(c) of the Act and all other applicable statute and regulations. Some states may determine that implementing a retrospective DSH payment methodology or a DSH reconciliation in their state plan is a reasonable way to manage its DSH allotment and ensure that payments made in excess of hospital-specific DSH limits are redistributed to hospitals that have not exceeded their limits. Although the state may have to modify definitions provided to hospitals in determining the hospital-specific DSH limit, the potential effect on the calculation of these limits would not result in an increase or decrease in the amount of FFP available to states for aggregate DSH payments made to hospitals.

## 2. Effects on Providers

This final rule defines “individuals who have no health insurance (or other source of third party coverage) for the services furnished during the year” for purposes of calculating the hospital-specific DSH limit effective for 2011. This final rule also provides additional clarification to states and hospitals regarding costs eligible for inclusion in the calculation of the hospital-specific DSH limit. This final rule may affect the calculation of the hospital-specific DSH limit established at section 1923(g) of the Act. Hospitals, if directly affected by the final

rule, should have higher DSH eligible costs. This increase in eligible costs would result in an increase in the hospital-specific DSH limit of these affected hospitals. In particular, DSH hospitals that provide a high volume of hospital services to American Indians/Alaska Natives where CHS payment is not authorized, individuals with creditable coverage but without coverage for the hospital services received as it relates to DSH costs, or individuals with limited coverage plans, lifetime limits, or exhausted benefits, may recognize an increase in their hospital-specific DSH limit. States are not required to increase DSH payments to affected hospitals based on increases in hospital-specific DSH limits.

The increased DSH limits, however, may mitigate the potential return of DSH payments to hospitals that would have been considered to exceed the hospital-specific DSH limit absent the provisions of this final rule. Additionally, states may reduce Medicaid DSH payments to certain providers and increase DSH payments to other providers as a result of changes to the hospital-specific DSH limit. Regardless, states alone are responsible in the management of their DSH allotment, retain the same flexibility to design DSH payment methodologies under the state plan, and are not required to increase or to decrease payments to providers as a result of this rule. We do not have national data that isolates the impact of this rule on hospital-specific DSH limits or national DSH payments. Based on the lack of data and the factors described above, we cannot predict an accurate estimate of the impact on individual hospitals or groups of hospitals.

### C. Alternatives Considered

In developing this rule, the following alternatives were considered. We considered not revising the definition of uninsured for purposes of determining the Medicaid DSH hospital-specific limit. However, we believe the individual-specific application of the definition of “uninsured” under the current rule effectively precludes recognition of uncompensated care costs for many services for which an individual is uninsured and has no third party coverage. Costs affected also include those associated with individuals who have reached health coverage limits, including annual or lifetime insurance limits, for certain services; have limited coverage through

IHS or tribal health programs; or have inadequate insurance benefit packages.

An alternative approach that we considered when developing this rule was to broaden even further the definition of uninsured to take into account costs associated with bad debt and prisoners. However, we believe that such an approach would not be consistent with the intent of both the hospital-specific limit and with the general exclusion of payment for services furnished to prisoners.

#### D. Accounting Statement and Table

As required by OMB Circular A-4 (available at [http://www.whitehouse.gov/omb/circulars\\_a004\\_a-4/](http://www.whitehouse.gov/omb/circulars_a004_a-4/)), we have prepared an accounting statement table showing the classification of the impacts associated with implementation of this final rule.

Accounting Table

Category	Estimate
Transfers	Qualitative assessment of impacts as a result of this final rule may result in transfers that exceed \$100 million in a given year.  To: hospitals whose DSH limits increase From: other disproportionate share hospitals

#### E. Conclusion

For the reasons discussed above, this rule has been designated an “economically significant” rule under section 3(f)(1) of Executive Order 12866, since it may have an economic impact in excess of \$100 million on a substantial number of small entities or on a substantial number of small rural hospitals. We do not have definitive national data that isolates the impact of this rule on hospital-specific DSH limits or national DSH payments. Due to the lack of this data we are unable to predict and estimate the impacts of this final rule, including those of individual hospitals or groups of hospitals.

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

#### **List of Subjects in 42 CFR Part 447**

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



For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services amends 42 CFR Part 447 as set forth below:

## **Title 42--Public Health**

### **PART 447 —PAYMENTS FOR SERVICES**

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

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

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

2. Add § 447.295 to read as follows:

##### **§ 447.295--Hospital-Specific Disproportionate Share Hospital Payment Limit:**

###### **Determination of Individuals without Health Insurance or Other Third Party Coverage.**

(a) Basis and purpose. This section sets forth the methodology for determining the costs for individuals who have no health insurance or other source of third party coverage for services furnished during the year for purposes of calculating the hospital-specific disproportionate share hospital payment limit under section 1923(g) of the Act.

(b) Definitions.

Individuals who have no health insurance (or other source of third party coverage) for the services furnished during the year means individuals who have no source of third party coverage for the specific inpatient hospital or outpatient hospital service furnished by the hospital.

Health insurance coverage limit means a limit imposed by a third party payer that establishes a maximum dollar value or maximum number of specific services, for benefits received by an individual.

No source of third party coverage for a specific inpatient hospital or outpatient hospital service means that the service is not included in an individual's health benefits coverage through a group health plan or health insurer, and for which there is no other legally liable third party. When a health insurance coverage limit is imposed by a third party payer, specific services beyond the

limit would not be within the individual's health benefit package from that third party payer. For American Indians/Alaska Natives, IHS and tribal coverage is only considered third party coverage when services are received directly from IHS or tribal health programs (direct health care services) or when IHS or a tribal health program has authorized coverage through the contract health service program (through a purchase order or equivalent document). Administrative denials of payment, or requirements for satisfaction of deductible, copayment or coinsurance liability, do not affect the determination that a specific service is included in the health benefits coverage.

(c) Determination of an individual's third party coverage status. Individuals who have no source of third party coverage for a specific inpatient hospital or outpatient hospital service must be considered, for purposes of that service, to be uninsured. This determination is not dependent on the receipt of payment by the hospital from the third party.

(1) The determination of an individual's status as having a source of third party coverage must be a service-specific coverage determination. The service-specific coverage determination can occur only once per individual per service provided and applies to the entire service, including all elements as that service, or similar services, would be defined in Medicaid.

(2) Individuals who are inmates in a public institution or are otherwise involuntarily in secure custody as a result of criminal charges are considered to have a source of third party coverage.

(d) Hospital-specific DSH limit calculation. Only costs incurred in providing inpatient hospital and outpatient hospital services to Medicaid individuals, and revenues received with respect to those services, and costs incurred in providing inpatient hospital and outpatient hospital services, and revenues received with respect to those services, for which a determination has been made in accordance with paragraph (c) of this section that the services were furnished to individuals who have no source of third party coverage for the specific inpatient hospital or outpatient hospital service are included when calculating the costs and revenues for Medicaid individuals and individuals who have no health insurance or other source of third party coverage

for purposes of section 1923(g)(1) of the Act.

Dated: September 26, 2014

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**Marilyn Tavenner,**  
Administrator,  
Centers for Medicare & Medicaid  
Services.

Dated: November 19, 2014

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**Sylvia M. Burwell,**  
Secretary.  
Department of Health and Human  
Services.

**BILLING CODE 4120-01-P**