H. Executive Order 13211: Actions That Significantly Affect Energy Supply, Distribution, or Use

This action is not subject to Executive Order 13211 (66 FR 28355, May 22, 2001), because it is not a significant regulatory action under Executive Order 12866.

I. National Technology Transfer Advancement Act

Section 12(d) of the National Technology Transfer and Advancement Act of 1995 (''NTTAA''), Public Law 104–113, 12(d) (15 U.S.C. 272 note) directs EPA to use voluntary consensus standards in its regulatory activities unless to do so would be inconsistent with applicable law or otherwise impractical. Voluntary consensus standards are technical standards (e.g., materials specifications, test methods, sampling procedures, and business practices) that are developed or adopted by voluntary consensus standards bodies. NTTAA directs EPA to provide Congress, through OMB, explanations when the Agency decides not to use available and applicable voluntary consensus standards.

This action does not involved technical standards. Therefore, EPA did not consider the use of any voluntary consensus standards.

J. Executive Order 12898: Federal Actions To Address Environmental Justice in Minority Populations and Low-Income Populations

Executive Order 12898 (59 FR 7629, Feb. 16, 1994) establishes federal executive policy on environmental justice. Its main provision directs federal agencies, to the greatest extent practicable and permitted by law, to make environmental justice part of their mission by identifying and addressing, as appropriate, disproportionately high and adverse human health or environmental effects of their programs, policies, and activities on minority populations and low-income populations in the United States.

EPA has determined that this proposed rule would not have disproportionately high and adverse human health or environmental effects on minority or low-income populations because it increases the level of environmental protection for all affected populations without having any disproportionately high and adverse human health or environmental effects on any population, including any minority or low-income population. This proposed rule would merely add an automatic waiver provision to encourage Great Lakes steamship owners to repower their vessels with cleaner marine diesel engines. To the extent Great Lakes steamship owners take advantage of this incentive program, their action would provide immediate air quality and energy benefits, due to the improved fuel efficiency of the diesel engines, and even larger benefits in the long term, when the repowered ship would use fuel that complies with the 1,000 ppm sulfur limit on the Great Lakes. These emission reductions would improve air quality for all people who live in the Great Lakes region, including minority and low-income populations.

K. Statutory Authority

The statutory authority for this action comes from section 1903 of the Act to Prevent Pollution from Ships (33 U.S.C. 1901 *et seq.*). The Act to Prevent Pollution from Ships implements Annex VI to the International Convention for the Prevention of Pollution from Ships (MARPOL) and makes those requirements enforceable domestically. Section 1903 gives the Administrator the authority to prescribe any necessary or desired regulations to carry out the provisions of Regulations 12 through 19 of MARPOL Annex VI.

List of Subjects in 40 CFR Part 1043

Environmental protection, Administrative practice and procedure, Air pollution control, Confidential business information, Economic hardship waiver, Great Lakes, North American Emission Control Area, Reporting and recordkeeping requirements, Steamships.

Dated: January 11, 2012.

Lisa P. Jackson,

Administrator.

[FR Doc. 2012–820 Filed 1–17–12; 8:45 am]

BILLING CODE 6560–50–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 447

[CMS–2315–P]

RIN 0938–AQ37

Medicaid Program; Disproportionate Share Hospital Payments—Uninsured Definition

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

ACTION: Proposed rule.

SUMMARY: This proposed rule addresses the hospital-specific limitation on Medicaid disproportionate share hospital (DSH) payments under the Social Security 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 would provide that the quoted phrase would refer in context to a lack of coverage on a service-specific basis, so that the calculation of uncompensated care for purposes of the hospital-specific DSH limit would include the cost of each service furnished to an individual who had no health insurance or other source of third party coverage for that service.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on February 17, 2012.

ADDRESSES: In commenting, please refer to file code CMS–2315–P. Because of staff and resource limitations, we cannot accept comments by facsimile (Fax) transmission.

You may submit comments in one of four ways (please choose only one of the ways listed):

1. *Electronically.* You may submit electronic comments on this regulation to *http://www.regulations.gov*. Follow the ''Submit a comment'' instructions.

2. *By regular mail.* You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–2315–P, P.O. Box 8016, Baltimore, MD 21244–8016.

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

3. *By express or overnight mail.* You may send written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–2315–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

4. *By hand or courier.* Alternatively, you may deliver (by hand or courier) your written comments ONLY to the following addresses prior to the close of the comment period:

a. For delivery in Washington, DC—Centers for Medicare & Medicaid Services, Department of Health and Human Services, Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue SW., Washington, DC 20201.

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without Federal government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

b. For delivery in Baltimore, MD—Centers for Medicare & Medicaid Services, Department of Health and Human Services, 7500 Security Boulevard, Baltimore, MD 21244–1850.

If you intend to deliver your comments to the Baltimore address, call telephone number (410) 786–9994 in advance to schedule your arrival with one of our staff members.

Comments erroneously mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

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

FOR FURTHER INFORMATION CONTACT: Rory Howe (410) 786–4878.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been received: *http://www.regulations.gov*. Follow the search instructions on that Web site to view public comments.

Comments received timely will also be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1–(800) 743–3951.

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'' (herein referred to as the 2008 DSH final rule) that implemented section 1001 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), 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 Part 144 and 45 CFR Part 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 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 proposed 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.

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 difference between 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.

Section 1923(a) and section 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 simply creates hospital-specific limitations on FFP for DSH payments to individual hospitals. These limits are comprised of specific 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 provided during the year. The statutory language uses the term ''services provided'' when discussing allowable uninsured costs. The use of this term provides a clear link to third party coverage of specific services provided by the hospital.

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 for which 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

Based on several U.S. Department of Health & Human Services Office of Inspector General (OIG) audits and U.S. Government Accountability Office (GAO) reports detailing violations in the DSH program, there was concern that CMS did not have the 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 within their DSH programs. Section 1001(d) of MMA added new audit and reporting requirements. Specifically, section 1923(j)(1) of the Act 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 Part 144 and 45 CFR Part 146. The regulatory definition of creditable coverage at 45 CFR Part 144 and 45 CFR Part 146 was developed to implement, in part, the Health Insurance Portability and Accountability Act (HIPAA) of 1996 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 45 CFR 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.

The issue involving IHS and tribal programs arises because IHS coverage is within the scope of ''creditable coverage'' under the regulations at 45 CFR Part 144 and 45 CFR Part 146, and thus individuals with such 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 is not 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 propose 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 such 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 performed in the same manner as for 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 current regulation and hospital services provided to individuals with creditable coverage but without coverage for specific hospital services received. By utilizing the existing regulatory creditable coverage definition an individual is considered either to have coverage, as broadly described in regulation, or not to have coverage during the period a hospital service was provided. If a service was provided to an individual with creditable coverage at the time of the provision of such service, that service cannot be considered provided to an uninsured individual. 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 such 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 which are 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 such a situation would involve 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. An additional 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). Though 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 Rule

A. Definition of Uninsured Under Section 1923(g) of the Act

We are proposing to add 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) would describe 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.''

We are proposing at § 447.295(b) to define 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. Proposed § 447.295(b) would also provide specific definitions for the terms ''service-specific coverage determination'' and ''lifetime or annual health insurance coverage limit.''

In this proposed rule, we are proposing to define ''individuals who have no health insurance (or other source of third party coverage) for the services furnished during the year'' for purposes of calculating the hospital-specific DSH limit on a service-specific basis rather than on an individual basis, and thus would not make reference to the regulatory definition of creditable coverage. The proposed definition would instead require a determination of whether, for each specific service furnished during the year, the individual has third party coverage. We are also proposing a 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, and is not covered by another legally liable third party. We would specify that services beyond annual or lifetime limits on insurance coverage would 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 would consider them as such for this purpose. We propose to consider 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 proposed 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. We are, however, proposing to include in § 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.

Thus, we are proposing at § 447.295(c) to specify 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. 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 would 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 proposed rule would also clarify 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 creditable 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. 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 proposed clarification would be 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 proposed rule would provide some relief for certain costs by allowing their inclusion in the calculation of the hospital-specific DSH limit, we also 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

We are proposing to clarify 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, and payer discounts 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 proposed 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 expressly 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 proposed rule would reiterate that the allowability of these costs has not changed under the proposed definition.

D. Prisoners

This proposed rule would clarify that the proposed 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 or are otherwise involuntarily held in secure custody as a result of criminal charges are considered to have a source of third party coverage. These individuals are in secure custody pursuant to the authority held by Federal, State or local law enforcement agencies, and those agencies are legally liable for the cost of their care (even if that agency has contracted with private parties for that secure custody). Moreover, the exclusion of such costs is consistent with the exclusion of such costs from the definition of ''Medical assistance'' in the statutory text at paragraph (A) following section 1905(a)(28) of the Act. Accordingly, the costs associated with providing hospital services to these individuals cannot be included in calculating the hospital-specific DSH limit.

The proposed definition of ''individuals who have no health insurance (or other source of third party coverage) for the services furnished during the year'' as it relates to prisoner inmate care would be consistent with the statute, regulations, and longstanding CMS policy regarding the treatment of inmates of public institutions for purposes of Medicaid eligibility and Medicaid DSH. A policy clarification regarding prisoner inmate care and DSH was provided in a SMD letter dated August 16, 2002. This proposed rule would serve to define more definitively who is considered a prisoner inmate for purposes of DSH.

The policy that inmates have third party coverage, based on the assumption that their care is the responsibility of the

responsible law enforcement or corrections agency, is consistent with the statutory framework that focuses on the distinction between an ''inmate'' and a ''patient.'' While the statutory provision at section 1905(a)(28)(A) of the Act generally excludes FFP for all care furnished to inmates of public institutions, there is a statutory exception for patients in a medical institution. We interpret this exception to be limited to when the individual is no longer in secure custody by law enforcement or a corrections agency and thus can be admitted as a ''patient'' rather than as an ''inmate'' to a hospital, nursing facility, juvenile psychiatric facility, or intermediate care facility. This is consistent with the fact that hospitals, or other institutional facilities cannot, within the scope of their conditions of participation, subject patients to restraints or seclusion. Thus individuals held in secure custody would be outside the function of the institution as a Medicaid-participating hospital and could not be treated as ''patients.'' Accordingly, FFP is available for Medicaid covered hospital services (or other covered institutional care) for Medicaid-eligible individuals referred from or by law enforcement or corrections authorities, or their contractors only to the extent that they have been released from secure custody, and all other requirements under the State plan are met. Applying this interpretation of the statutory exclusion and exception to the hospital-specific limits for DSH, costs and revenues associated with hospital services for individuals (whether Medicaid eligible or uninsured) referred from or by law enforcement or corrections authorities, or their contractors would be included in calculating the limit only to the extent that the individual has been released from secure custody by law enforcement or a corrections agency.

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

We are proposing at § 447.295(d) to specify 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 proposed section would ensure 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. Collection of Information Requirements

This document does not impose information collection and recordkeeping requirements. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. Chapter 35).

IV. Response to Comments

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

V. Regulatory Impact Statement

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). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year). This rule does not reach the economic threshold and thus is not considered a major rule.

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 $7.0 million to $34.5 million in any 1 year. Individuals and States are not included in the definition of a small entity. We are not preparing an analysis for the RFA because we have determined, and the Secretary certifies, that this proposed rule would not have a significant economic impact on a substantial number of small entities.

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 603 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area for Medicare payment regulations and has fewer than 100 beds. We are not preparing an analysis for section 1102(b) of the Act because we have determined, and the Secretary certifies, that this proposed rule would not have a significant impact on the operations of a substantial number of small rural hospitals.

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 2011, that threshold is approximately $136 million. This rule would have no consequential effect 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 proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. Since this regulation does not impose any costs on State or local governments, the requirements of Executive Order 13132 are not applicable.

To the extent that this proposed rule will have tribal implications, and in accordance with E.O. 13175 and the HHS Tribal Consultation Policy (December 2010), CMS will consult 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 proposed 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 proposed 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 proposed 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 proposed 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 proposed 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 proposed 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 proposed rule also provides additional clarification to States and hospitals regarding costs eligible for inclusion in the calculation of the hospital-specific DSH limit. This proposed rule may affect the calculation of the hospital-specific DSH limit established at section 1923(g) of the Act. Hospitals, if affected by the proposed rule, should have higher DSH eligible costs. This increase in eligible costs would result in an increase in the hospital-specific DSH limit of 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 proposed rule.

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 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. We welcome comments not only on the provisions of this rule, in whole or in part, but also on alternatives that may more constructively address the underlying problems and their likely impacts on States, hospitals, and individuals receiving services in disproportionate share hospitals.

D. Conclusion

For the reasons discussed above, we are not preparing analysis for either the RFA or section 1102(b) of the Act because we have determined that this regulation would not have a direct significant economic impact on a substantial number of small entities or a direct significant impact on the operations of a substantial number of small rural 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 proposes to amend 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.

Lifetime or annual health insurance coverage limit means an annual or lifetime limit, imposed by a third party payer, that establishes a maximum dollar value, or maximum number of specific services, on a lifetime or annual basis, 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 lifetime or annual 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.

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

Dated: March 30, 2011.

Donald M. Berwick,

Administrator, Centers for Medicare & Medicaid Services.

Approved: October 31, 2011.

Kathleen Sebelius,

Secretary, Department of Health and Human Services.

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