INSTRUCTIONS TO VENDORS SUBMITTING BIDS

1. REVIEW DOCUMENTS THOROUGHLY: The attached documents contain a solicitation for bids. Please read these instructions and all documents attached in their entirety. These instructions provide critical information about requirements that if overlooked could lead to disqualification of a Vendor's bid. All bids must be submitted in accordance with the provisions contained in these instructions and the Solicitation. Failure to do so may result in disqualification of Vendor's bid.

2. MANDATORY TERMS: The Solicitation may contain mandatory provisions identified by the use of the words "must," "will," and "shall." Failure to comply with a mandatory term in the Solicitation will result in bid disqualification.

3. PREBID MEETING: The item identified below shall apply to this Solicitation.

[ ] A pre-bid meeting will not be held prior to bid opening.

[ ] A **NON-MANDATORY PRE-BID** meeting will be held at the following place and time:

[**X**] A **MANDATORY PRE-BID** meeting will be held at the following place and time:

West Virginia Department of Health and Human Resources
Bureau for Medical Services
350 Capitol Street, Room 251
Charleston, West Virginia 25301
Date/Time: January 10, 2013 at 1:30 PM EST

All Vendors submitting a bid must attend the mandatory pre-bid meeting. Failure to attend the mandatory pre-bid meeting shall result in disqualification of the Vendor's bid. No one person attending the pre-bid meeting may represent more than one Vendor.

An attendance sheet provided at the pre-bid meeting shall serve as the official document verifying attendance. The DHHR Office of Purchasing will not accept any other form of proof or documentation to verify attendance. Any person attending the pre-bid meeting on behalf of a Vendor must list on the attendance sheet his or her name and the name of the Vendor he or she is representing. Additionally, the person attending the pre-bid meeting should include the Vendor's E-Mail address, phone number, and Fax number on the attendance sheet. It is the Vendor's responsibility to locate the attendance sheet and provide the required information. Failure to complete the attendance sheet as required may result in disqualification of Vendor's bid.

All Vendors should arrive prior to the starting time for the pre-bid. Vendors who arrive after the starting time but prior to the end of the pre-bid will be permitted to sign in, but are charged with knowing all matters discussed at the pre-bid.

Questions submitted at least five business days prior to a scheduled pre-bid will be discussed at the pre-bid meeting if possible. Any discussions or answers to questions at the pre-bid meeting are preliminary in nature and are non-binding. Official and binding answers to questions will be published in a written addendum to the Solicitation prior to bid opening.

4. VENDOR QUESTION DEADLINE: Vendors may submit questions relating to this Solicitation to the DHHR Office of Purchasing. Questions must be submitted in writing. All questions must be submitted on or before the date listed below and to the address listed below in order to be considered. A written response will be published in a Solicitation addendum if a response is possible and appropriate. Non-written discussions, conversations, or questions and answers regarding this Solicitation are preliminary in nature and are non-binding.

Question Submission Deadline: January 24, 2013 at 5:00 PM EST

Submit Questions to:

DHHR Office of Purchasing
ATTN: Robert Price, Buyer
One Davis Square, Suite 100
Charleston, WV 25301

Fax: (304) 558-2892

Email: Robert.L.Price@wv.gov

5. VERBAL COMMUNICATION: Any verbal communication between the Vendor and any State personnel is not binding, including that made at the mandatory pre-bid conference. Only information issued in writing and added to the Solicitation by an official written addendum by the DHHR Office of Purchasing is binding.

6. BID SUBMISSION: All bids must be signed and delivered by the Vendor to the DHHR Office of Purchasing at the address listed below on or before the date and time of the bid opening. Any bid received by the DHHR Office of Purchasing staff is considered to be in the possession of the DHHR Office of Purchasing and will not be returned for any reason. The bid delivery address is:

DHHR Office of Purchasing
One Davis Square, Suite 100
Charleston, WV 25301

The bid should contain the information listed below on the face of the envelope or the bid may not be considered:

SEALED BID

BUYER: _____

SOLICITATION NO.: _____

BID OPENING DATE: _____

BID OPENING TIME: _____

FAX NUMBER: _____

Vendor shall submit one original quotation plus four (4) convenience copies to the DHHR Office of Purchasing at the address shown above. In the event that Vendor is responding to a request for proposal, the Vendor shall submit one original technical and one original cost proposal plus N/A convenience copies of each to the DHHR Office of Purchasing at the address shown above. Additionally, the Vendor should identify the bid type as either a technical or cost proposal on the face of each bid envelope submitted in response to a request for proposal as follows:

BID TYPE:

[ ] Technical

[ ] Cost

7. BID OPENING: Bids submitted in response to this Solicitation will be opened at the location identified below on the date and time listed below. Delivery of a bid after the bid opening date and time will result in bid disqualification. For purposes of this Solicitation, a bid is considered delivered when time stamped by the official DHHR Office of Purchasing time clock.

Bid Opening Date and Time: February 21, 2013 at 1:30 PM EST

Bid Opening Location : DHHR Office of Purchasing

One Davis Square, Suite 100

Charleston, WV 25301

8. ADDENDUM ACKNOWLEDGEMENT: Changes or revisions to this Solicitation will be made by an official written addendum issued by the DHHR Office of Purchasing. Vendor should acknowledge receipt of all addenda issued with this Solicitation by completing an Addendum Acknowledgment Form, a copy of which is included herewith. Failure to acknowledge addenda may result in bid disqualification. The addendum acknowledgement should be submitted with the bid to expedite document processing.

9. BID FORMATTING: Vendor should type or electronically enter the information onto its bid to prevent errors in the evaluation. Failure to type or electronically enter the information may result in bid disqualification.

GENERAL TERMS AND CONDITIONS:

1. CONTRACTUAL AGREEMENT: Issuance of a Purchase Order signed by the DHHR Secretary, and approved as to form constitutes acceptance of this Contract made by and between the State of West Virginia and the Vendor. Vendor's signature on its bid signifies Vendor's agreement to be bound by and accept the terms and conditions contained in this Contract.

2. DEFINITIONS: As used in this Solicitation / Contract, the following terms shall have the meanings attributed to them below. Additional definitions may be found in the specifications included with this Solicitation / Contract.

2.1 "Agency" or **"Agencies"** means the Bureau for Medical Services as identified on the first page of the Solicitation or any other public entity seeking to procure goods or services under this Contract.

2.2 "Contract" means the binding agreement that is entered into between the State and the Vendor to provide the goods and services requested in the Solicitation.

2.3 "Director" means the Director of the West Virginia Department of Health and Human Resources, Office of Purchasing.

2.4 "Office of Purchasing" means the West Virginia Department of Health and Human Resources, Office of Purchasing.

2.5 "Purchase Order" means the document signed by the DHHR Secretary, and approved as to form, that identifies the Vendor as the successful bidder and Contract holder.

2.6 "Solicitation" means the official solicitation published by the DHHR Office of Purchasing and identified by number on the first page thereof.

2.7 "State" means the State of West Virginia and/or any of its agencies, commissions, boards, etc. as context requires.

2.8 "Vendor" or **"Vendors"** means any entity submitting a bid in response to the Solicitation, the entity that has been selected as the lowest responsible bidder, or the entity that has been awarded the Contract as context requires.

3. CONTRACT TERM; RENEWAL; EXTENSION: The term of this Contract shall be determined in accordance with the category that has been identified as applicable to this Contract below:

[X] Term Contract

Initial Contract Term: This Contract becomes effective on [the date the purchase order is issued, the date the notice to proceed is received, etc.] and extends through December 31, 2013.

Renewal Term: This Contract may be renewed upon the mutual written consent of the Agency, and the Vendor, with approval of the DHHR Office of Purchasing. Any request for renewal must be submitted to the Medicaid program thirty (30) days prior to the expiration date of the initial contract term or appropriate renewal term. A Contract renewal shall be in accordance with the terms and conditions of the original contract. Renewal of this Contract is limited to two (2) successive one (1) year periods. Automatic renewal of this Contract is prohibited.

Reasonable Time Extension: At the sole discretion of the DHHR Office of Purchasing Director, this Contract may be extended for a reasonable time after the initial Contract term or after any renewal term as may be necessary to obtain a new contract or renew this Contract. Any reasonable time extension shall not exceed twelve (12) months, unless there are extenuating circumstances necessitating the extension as described in the West Virginia Bureau for Medical Services Medicaid Services Contracts Purchasing Manual. Vendor may avoid a reasonable time extension by providing the Bureau for Medical Services with written notice of Vendor's desire to terminate this Contract 30 days prior to the expiration of the then current term. During any reasonable time extension period, the

Vendor may terminate this Contract for any reason upon giving the Bureau for Medical Services 30 days written notice.

[ ] Fixed Period Contract: This Contract becomes effective upon Vendor's receipt of the notice to

proceed and must be completed within days.

[ ] One Time Purchase: The term of this Contract shall run for one year from the date the Purchase Order is issued or from the date the Purchase Order is issued until all of the goods contracted for have been delivered, whichever is shorter.

[ ] Other: See attached.

4. NOTICE TO PROCEED: Vendor shall begin performance of this Contract immediately upon receiving notice to proceed unless otherwise instructed by the Agency. Unless otherwise specified, the fully executed Purchase Order will be considered notice to proceed

5. QUANTITIES: The quantities required under this Contract shall be determined in accordance with the category that has been identified as applicable to this Contract below.

[ ] Open End Contract: Quantities listed in this Solicitation are approximations only, based on estimates supplied by the Agency. It is understood and agreed that the Contract shall cover the quantities actually ordered for delivery during the term of the Contract, whether more or less than the quantities shown.

[X] Service: The scope of the service to be provided will be more clearly defined in the specifications included herewith.

[ ] Combined Service and Goods: The scope of the service and deliverable goods to be provided will be more clearly defined in the specifications included herewith.

[ ] One Time Purchase: This Contract is for the purchase of a set quantity of goods that are identified in the specifications included herewith. Once those items have been delivered, no additional goods may be procured under this Contract without an appropriate change order approved by the Vendor, Agency, DHHR Office of Purchasing.

6. PRICING: The pricing set forth herein is firm for the life of the Contract, unless specified elsewhere within this Solicitation/Contract by the State. A Vendor's inclusion of price adjustment provisions in its bid, without an express authorization from the State in the Solicitation to do so, may result in bid disqualification.

7. EMERGENCY PURCHASES: The DHHR Office of Purchasing Director may authorize the Agency to purchase goods or services in the open market that Vendor would otherwise provide under this Contract if those goods or services are for immediate or expedited delivery in an emergency. Emergencies shall include, but are not limited to, delays in transportation or an unanticipated increase in the volume of work. An emergency purchase in the open market, approved by the DHHR Office of Purchasing Director, shall not constitute of breach of this Contract and shall not entitle the Vendor to any form of compensation or damages. This provision does not excuse the State from fulfilling its obligations under a One Time Purchase contract.

8. REQUIRED DOCUMENTS: All of the items checked below must be provided to the DHHR Office of Purchasing by the Vendor as specified below.

[ ] BID BOND: All Vendors shall furnish a bid bond in the amount of five percent (5%) of the total amount of the bid protecting the State of West Virginia. The bid bond must be submitted with the bid.

[ ] PERFORMANCE BOND: The apparent successful Vendor shall provide a performance bond in the amount of [100% of the Contract value or $_____]. The performance bond must be issued and received by the DHHR Office of Purchasing prior to Contract award. On construction contracts, the performance bond must be 100% of the Contract value.

[ ] LABOR/MATERIAL PAYMENT BOND: The apparent successful Vendor shall provide a labor/material payment bond in the amount of 100% of the Contract value. The labor/material payment bond must be issued and delivered to the DHHR Office of Purchasing prior to Contract award.

In lieu of the Bid Bond, Performance Bond, and Labor/Material Payment Bond, the Vendor may provide certified checks, cashier's checks, or irrevocable letters of credit. Any certified check, cashier's check, or irrevocable letter of credit provided in lieu of a bond must be of the same amount and delivered on the same schedule as the bond it replaces. A letter of credit submitted in lieu of a performance and labor/material payment bond will only be allowed for projects under $100,000. Personal or business checks are not acceptable.

[ ] MAINTENANCE BOND: The apparent successful Vendor shall provide a two (2) year maintenance bond covering the roofing system. The maintenance bond must be issued and delivered to the DHHR Office of Purchasing prior to Contract award.

[X] WORKERS' COMPENSATION INSURANCE: The apparent successful Vendor shall have appropriate workers' compensation insurance and shall provide proof thereof upon request.

[ ] INSURANCE: The apparent successful Vendor shall furnish proof of the following insurance prior to Contract award:

[X] Commercial General Liability Insurance:

Public liability: Minimum of $500,000.00 per person, and $1,000,000.00 per occurrence.
• Property damage: Minimum of $1,000,000.00 per occurrence.
• Professional liability (medical, advertising, et cetera): Minimum of $1,000,000.00 per occurrence.

[ ] **Builders Risk Insurance:** builders risk – all risk insurance in an amount equal to 100% of the amount of the Contract.

[ ] [Insert required insurance]

[ ] [Insert required insurance]

[ ] [Insert required insurance]

[ ] [Insert required insurance]

[ ] [Insert required insurance]

The apparent successful Vendor shall also furnish proof of any additional insurance requirements contained in the specifications prior to Contract award regardless of whether or not that insurance requirement is listed above.

[ ] LICENSE(S) / CERTIFICATIONS / PERMITS: In addition to anything required under the Section entitled Licensing, of the General Terms and Conditions, the apparent successful Vendor shall furnish proof of the following licenses, certifications, and/or permits prior to Contract award, in a form acceptable to the DHHR Office of Purchasing.

[ ] [Insert required license or certification]

[ ] [Insert required license or certification]

[ ] [Insert required license or certification]

[ ] [Insert required license or certification]

The apparent successful Vendor shall also furnish proof of any additional licenses or certifications contained in the specifications prior to Contract award regardless of whether or not that requirement is listed above.

9. LITIGATION BOND: Any Vendor that has submitted a litigation bond with their bid has the right to protest contract awards. The litigation bond required for this bid will be $11,000. The entire bond shall be forfeited if the hearing officer determines that the protest was filed for frivolous or improper purpose, including but not limited to, the purpose of harassing, causing unnecessary delay, or needless expense for the Agency. All litigation bonds shall be made payable to the DHHR Office of Purchasing. In lieu of a bond, the protester may submit a cashier's check or certified check payable to the DHHR Office

of Purchasing. Cashier's or certified checks will be deposited with and held by the State Treasurer's office. If it is determined that the protest has not been filed for frivolous or improper purpose, the bond or deposit shall be returned in its entirety.

10. ALTERNATES: Any model, brand, or specification listed herein establishes the acceptable level of quality only and is not intended to reflect a preference for, or in any way favor, a particular brand or vendor. Vendors may bid alternates to a listed model or brand provided that the alternate is at least equal to the model or brand and complies with the required specifications. The equality of any alternate being bid shall be determined by the State at its sole discretion. Any Vendor bidding an alternate model or brand should clearly identify the alternate items in its bid and should include manufacturer's specifications, industry literature, and/or any other relevant documentation demonstrating the equality of the alternate items. Failure to provide information for alternate items may be grounds for rejection of a Vendor's bid.

11. EXCEPTIONS AND CLARIFICATIONS: The Solicitation contains the specifications that shall form the basis of a contractual agreement. Vendor shall clearly mark any exceptions, clarifications, or other proposed modifications in its bid. Exceptions to, clarifications of, or modifications of a requirement or term and condition of the Solicitation may result in bid disqualification.

12. LIQUIDATED DAMAGES: Vendor shall pay liquidated damages in the amount of $ 1,000 per day for failure to meet contract deliverables and specified deadlines. This clause shall in no way be considered exclusive and shall not limit the State or Agency's right to pursue any other available remedy.

13. ACCEPTANCE/REJECTION: The State may accept or reject any bid in whole, or in part. Vendor's signature on its bid signifies acceptance of the terms and conditions contained in the Solicitation and Vendor agrees to be bound by the terms of the Contract, as reflected in the Purchase Order, upon receipt.

14. REGISTRATION: Prior to Contract award, the apparent successful Vendor must be properly registered with the West Virginia Purchasing Division and must have paid the $125 fee if applicable.

15. COMMUNICATION LIMITATIONS: Communication with the State of West Virginia or any of its employees regarding this Solicitation during the solicitation, bid, evaluation or award periods, except through the DHHR Office of Purchasing, is strictly prohibited without prior DHHR Office of Purchasing

approval. DHHR Office of Purchasing approval for such communication is implied for all agency delegated and exempt purchases.

16. FUNDING: This Contract shall continue for the term stated herein, contingent upon funds being appropriated by the Legislature or otherwise being made available. In the event funds are not appropriated or otherwise made available, this Contract becomes void and of no effect beginning on July 1 of the fiscal year for which funding has not been appropriated or otherwise made available.

17. PAYMENT: Payment in advance is prohibited under this Contract. Payment may only be made after the delivery and acceptance of goods or services. The Vendor shall submit invoices, in arrears, to the Agency at the address on the face of the purchase order labeled "Invoice To."

18. UNIT PRICE: Unit prices shall prevail in cases of a discrepancy in the Vendor's bid.

19. DELIVERY: All quotations are considered freight on board destination ("F.O.B. destination") unless alternate shipping terms are clearly identified in the bid. Vendor's listing of shipping terms that contradict the shipping terms expressly required by this Solicitation may result in bid disqualification.

20. INTEREST: Interest attributable to late payment will only be permitted if authorized by the West Virginia Code. Presently, there is no provision in the law for interest on late payments.

21. PREFERENCE: Vendor Preference may only be granted upon written request. A Resident Vendor Certification form has been attached hereto to allow Vendor to apply for the preference. Vendor's failure to submit the Resident Vendor Certification form with its bid will result in denial of Vendor Preference. Vendor Preference does not apply to construction projects.

22. TAXES: The Vendor shall pay any applicable sales, use, personal property or any other taxes arising out of this Contract and the transactions contemplated thereby. The State of West Virginia is exempt from federal and state taxes and will not pay or reimburse such taxes.

23. CANCELLATION: The DHHR Secretary reserves the right to cancel this Contract immediately upon written notice to the vendor if the materials or workmanship supplied do not conform to the specifications contained in the Contract. The DHHR Office of Purchasing Director may cancel any purchase or Contract upon 30 days written notice to the Vendor.

24. WAIVER OF MINOR IRREGULARITIES: The Director reserves the right to waive minor irregularities in bids or specifications.

25. TIME: Time is of the essence with regard to all matters of time and performance in this Contract.

26. APPLICABLE LAW: This Contract is governed by and interpreted under West Virginia law without giving effect to its choice of law principles. Any information provided in specification manuals, or any other source, verbal or written, which contradicts or violates the West Virginia Constitution, West Virginia Code or West Virginia Code of State Rules is void and of no effect.

27. COMPLIANCE: Vendor shall comply with all applicable federal, state, and local laws, regulations and ordinances. By submitting a bid, Vendors acknowledge that they have reviewed, understand, and will comply with all applicable law.

28. ARBITRATION: Any references made to arbitration contained in this Contract, Vendor's bid, or in any American Institute of Architects documents pertaining to this Contract are hereby deleted, void, and of no effect.

29. MODIFICATIONS: This writing is the parties' final expression of intent. Notwithstanding anything contained in this Contract to the contrary, no modification of this Contract shall be binding without mutual written consent of the Agency, and the Vendor, with approval of the DHHR Office of Purchasing. **No Change shall be implemented by the Vendor until such time as the Vendor receives an approved written change order from the DHHR Office of Purchasing.**

30. WAIVER: The failure of either party to insist upon a strict performance of any of the terms or provision of this Contract, or to exercise any option, right, or remedy herein contained, shall not be construed as a waiver or a relinquishment for the future of such term, provision, option, right, or

remedy, but the same shall continue in full force and effect. Any waiver must be expressly stated in writing and signed by the waiving party.

31. SUBSEQUENT FORMS: The terms and conditions contained in this Contract shall supersede any and all subsequent terms and conditions which may appear on any form documents submitted by Vendor to the Agency or DHHR Office of Purchasing such as price lists, order forms, invoices, sales agreements, or maintenance agreements, and includes internet websites or other electronic documents. Acceptance or use of Vendor's forms does not constitute acceptance of the terms and conditions contained thereon.

32. ASSIGNMENT: Neither this Contract nor any monies due, or to become due hereunder, may be assigned by the Vendor without the express written consent of the Agency, the DHHR Office of Purchasing , and any other government agency or office that may be required to approve such assignments. Notwithstanding the foregoing, DHHR Office of Purchasing approval may or may not be required on certain agency delegated or exempt purchases.

33. WARRANTY: The Vendor expressly warrants that the goods and/or services covered by this Contract will: (a) conform to the specifications, drawings, samples, or other description furnished or specified by the Agency; (b) be merchantable and fit for the purpose intended; and (c) be free from defect in material and workmanship.

34. STATE EMPLOYEES: State employees are not permitted to utilize this Contract for personal use and the Vendor is prohibited from permitting or facilitating the same.

35. BANKRUPTCY: In the event the Vendor files for bankruptcy protection, the State of West Virginia may deem this Contract null and void, and terminate this Contract without notice.

36. HIPAA BUSINESS ASSOCIATE ADDENDUM: The West Virginia State Government HIPAA Business Associate Addendum (BAA), is available online at http://www.dhhr.wv.gov/bms/ProcurementNotices/Documents/HIPAA%20BAA_20100802.pdf and is hereby made part of the agreement provided that the Agency meets the definition of a Covered entity (45 CFR §160.103) and will be disclosing Protected Health Information (45 CFR §160.103) to the Vendor.

37. CONFIDENTIALITY: The Vendor agrees that it will not disclose to anyone, directly or indirectly, any such personally identifiable information or other confidential information gained from the Agency, unless the individual who is the subject of the information consents to the disclosure in writing or the disclosure is made pursuant to the Agency's policies, procedures, and rules. Vendor further agrees to comply with the Confidentiality Policies and Information Security Accountability Requirements, set forth in http://www.state.wv.us/admin/purchase/privacy/default.html.

38. DISCLOSURE: Vendor's response to the Solicitation and the resulting Contract are considered public documents and will be disclosed to the public in accordance with the laws, rules, and policies governing the West Virginia DHHR Office of Purchasing. Those laws include, but are not limited to, the Freedom of Information Act found in West Virginia Code § 29B-1-1 et seq.

If a Vendor considers any part of its bid to be exempt from public disclosure, Vendor must so indicate by specifically identifying the exempt information, identifying the exemption that applies, providing a detailed justification for the exemption, segregating the exempt information from the general bid information, and submitting the exempt information as part of its bid but in a segregated and clearly identifiable format. Failure to comply with the foregoing requirements will result in public disclosure of the Vendor's bid without further notice. A Vendor's act of marking all or nearly all of its bid as exempt is not sufficient to avoid disclosure and WILL NOT BE HONORED. Vendor's act of marking a bid or any part thereof as "confidential" or "proprietary" is not sufficient to avoid disclosure and WILL NOT BE HONORED. In addition, a legend or other statement indicating that all or substantially all of the bid is exempt from disclosure is not sufficient to avoid disclosure and WILL NOT BE HONORED. Vendor will be required to defend any claimed exemption for nondisclosure in the event of an administrative or judicial challenge to the State's nondisclosure. Vendor must indemnify the State for any costs incurred related to any exemptions claimed by Vendor. Any questions regarding the applicability of the various public records laws should be addressed to your own legal counsel prior to bid submission.

39. LICENSING: Vendor must be licensed and in good standing in accordance with any and all state and local laws and requirements by any state or local agency of West Virginia, including, but not limited to, the West Virginia Secretary of State's Office, the West Virginia Tax Department, West Virginia Insurance Commission, or any other state agency or political subdivision. Upon request, the Vendor must provide all necessary releases to obtain information to enable the DHHR Office of Purchasing Director or the Agency to verify that the Vendor is licensed and in good standing with the above entities.

40. ANTITRUST: In submitting a bid to, signing a contract with, or accepting a Purchase Order from any agency of the State of West Virginia, the Vendor agrees to convey, sell, assign, or transfer to the State of West Virginia all rights, title, and interest in and to all causes of action it may now or hereafter acquire under the antitrust laws of the United States and the State of West Virginia for price fixing and/or

unreasonable restraints of trade relating to the particular commodities or services purchased or acquired by the State of West Virginia. Such assignment shall be made and become effective at the time the purchasing agency tenders the initial payment to Vendor.

41. VENDOR CERTIFICATIONS: By signing its bid or entering into this Contract, Vendor certifies (1) that its bid was made without prior understanding, agreement, or connection with any corporation, firm, limited liability company, partnership, person or entity submitting a bid for the same material, supplies, equipment or services; (2) that its bid is in all respects fair and without collusion or fraud; (3) that this Contract is accepted or entered into without any prior understanding, agreement, or connection to any other entity that could be considered a violation of law; and (4) that it has reviewed this RFQ in its entirety; understands the requirements, terms and conditions, and other information contained herein. Vendor's signature on its bid also affirms that neither it nor its representatives have any interest, nor shall acquire any interest, direct or indirect, which would compromise the performance of its services hereunder. Any such interests shall be promptly presented in detail to the Agency.

The individual signing this bid on behalf of Vendor certifies that he or she is authorized by the Vendor to execute this bid or any documents related thereto on Vendor's behalf; that he or she is authorized to bind the Vendor in a contractual relationship; and that, to the best of his or her knowledge, the Vendor has properly registered with any State agency that may require registration.

42. PURCHASING CARD ACCEPTANCE: The State of West Virginia currently utilizes a Purchasing Card program, administered under contract by a banking institution, to process payment for goods and services. The Vendor must accept the State of West Virginia's Purchasing Card for payment of all orders under this Contract unless the box below is checked.

[X] Vendor is not required to accept the State of West Virginia's Purchasing Card as payment for all goods and services.

43. VENDOR RELATIONSHIP: The relationship of the Vendor to the State shall be that of an independent contractor and no principal-agent relationship or employer-employee relationship is contemplated or created by this Contract. The Vendor as an independent contractor is solely liable for the acts and omissions of its employees and agents. Vendor shall be responsible for selecting, supervising, and compensating any and all individuals employed pursuant to the terms of this Solicitation and resulting contract. Neither the Vendor, nor any employees or subcontractors of the Vendor, shall be deemed to be employees of the State for any purpose whatsoever. Vendor shall be exclusively responsible for payment of employees and contractors for all wages and salaries, taxes, withholding payments, penalties, fees, fringe benefits, professional liability insurance premiums, contributions to insurance and pension, or other deferred compensation plans, including but not limited to, Workers' Compensation

and Social Security obligations, licensing fees, *etc.* and the filing of all necessary documents, forms and returns pertinent to all of the foregoing. Vendor shall hold harmless the State, and shall provide the State and Agency with a defense against any and all claims including, but not limited to, the foregoing payments, withholdings, contributions, taxes, Social Security taxes, and employer income tax returns.

44. INDEMNIFICATION: The Vendor agrees to indemnify, defend, and hold harmless the State and the Agency, their officers, and employees from and against: (1) Any claims or losses for services rendered by any subcontractor, person, or firm performing or supplying services, materials, or supplies in connection with the performance of the Contract; (2) Any claims or losses resulting to any person or entity injured or damaged by the Vendor, its officers, employees, or subcontractors by the publication, translation, reproduction, delivery, performance, use, or disposition of any data used under the Contract in a manner not authorized by the Contract, or by Federal or State statutes or regulations; and (3) Any failure of the Vendor, its officers, employees, or subcontractors to observe State and Federal laws including, but not limited to, labor and wage and hour laws.

45. PURCHASING AFFIDAVIT: All Vendors are required to sign, notarize, and submit the Purchasing Affidavit stating that neither the Vendor nor a related party owe a debt to the State in excess of $1,000. The affidavit must be submitted prior to award, but should be submitted with the Vendor's bid. A copy of the Purchasing Affidavit is included herewith.

46. ADDITIONAL AGENCY AND LOCAL GOVERNMENT USE: This Contract may be utilized by and extends to other agencies, spending units, and political subdivisions of the State of West Virginia; county, municipal, and other local government bodies; and school districts ("Other Government Entities"). This Contract shall be extended to the aforementioned Other Government Entities on the same prices, terms, and conditions as those offered and agreed to in this Contract. If the Vendor does not wish to extend the prices, terms, and conditions of its bid and subsequent contract to the Other Government Entities, the Vendor must clearly indicate such refusal in its bid. A refusal to extend this Contract to the Other Government Entities shall not impact or influence the award of this Contract in any manner.

47. CONFLICT OF INTEREST: Vendor, its officers or members or employees, shall not presently have or acquire any interest, direct or indirect, which would conflict with or compromise the performance of its obligations hereunder. Vendor shall periodically inquire of its officers, members and employees to ensure that a conflict of interest does not arise. Any conflict of interest discovered shall be promptly presented in detail to the Agency.

48. REPORTS: Vendor shall provide the Agency and/or the DHHR Office of Purchasing with the following reports identified by a checked box below:

[**X**] Such reports as the Agency and/or the DHHR Office of Purchasing may request. Requested reports may include, but are not limited to, quantities purchased, agencies utilizing the contract, total contract expenditures by agency, etc.

[ ] Quarterly reports detailing the total quantity of purchases in units and dollars, along with a listing of purchases by agency. Quarterly reports should be delivered to the DHHR Office of Purchasing via email at Bryan.D.Rosen@wv.gov.

49. BACKGROUND CHECK: In accordance with W. Va. Code § 15-2D-3, the Director of the Division of Protective Services shall require any service provider whose employees are regularly employed on the grounds or in the buildings of the Capitol complex or who have access to sensitive or critical information to submit to a fingerprint-based state and federal background inquiry through the state repository. The service provider is responsible for any costs associated with the fingerprint-based state and federal background inquiry.

After the contract for such services has been approved, but before any such employees are permitted to be on the grounds or in the buildings of the Capitol complex or have access to sensitive or critical information, the service provider shall submit a list of all persons who will be physically present and working at the Capitol complex to the Director of the Division of Protective Services for purposes of verifying compliance with this provision.

The State reserves the right to prohibit a service provider's employees from accessing sensitive or critical information or to be present at the Capitol complex based upon results addressed from a criminal background check. Service providers should contact the West Virginia Division of Protective Services by phone at (304) 558-9911 for more information.

CERTIFICATION AND SIGNATURE PAGE

By signing below, I certify that I have reviewed this Solicitation in its entirety; understand the requirements, terms and conditions, and other information contained herein; that I am submitting this bid or proposal for review and consideration; that I am authorized by the bidder to execute this bid or any documents related thereto on bidder's behalf; that I am authorized to bind the bidder in a contractual relationship; and that to the best of my knowledge, the bidder has properly registered with any State agency that may require registration.

_____

(Company)

_____

(Authorized Signature)

_____

(Representative Name, Title)

_____

(Phone Number) (Fax Number)

_____

(Date)

ADDENDUM ACKNOWLEDGEMENT FORM

SOLICITATION NO.:

Instructions: Please acknowledge receipt of all addenda issued with this solicitation by completing this addendum acknowledgment form. Check the box next to each addendum received and sign below. Failure to acknowledge addenda may result in bid disqualification.

Acknowledgment: I hereby acknowledge receipt of the following addenda and have made the necessary revisions to my proposal, plans and/or specification, etc.

Addendum Numbers Received:

(Check the box next to each addendum received)

[ ] Addendum No. 1 [ ] Addendum No. 6

[ ] Addendum No. 2 [ ] Addendum No. 7

[ ] Addendum No. 3 [ ] Addendum No. 8

[ ] Addendum No. 4 [ ] Addendum No. 9

[ ] Addendum No. 5 [ ] Addendum No. 10

I understand that failure to confirm the receipt of addenda may be cause for rejection of this bid. I further understand that any verbal representation made or assumed to be made during any oral discussion held between Vendor's representatives and any state personnel is not binding. Only the information issued in writing and added to the specifications by an official addendum is binding.

_____

Company

_____

Authorized Signature

_____

Date

NOTE: This addendum acknowledgement should be submitted with the bid to expedite document processing.

RFQ No. _____

BUREAU FOR MEDICAL SERVICES

MED PURCHASING AFFIDAVIT

West Virginia Code §5A-3-10a states: No contract or renewal of any contract may be awarded by the state or any of its political subdivisions to any vendor or prospective vendor when the vendor or prospective vendor or a related party to the vendor or prospective vendor is a debtor and the debt owned is an amount greater than one thousand dollars in the aggregate

DEFINITIONS:
"Debt" means any assessment, premium, penalty, fine, tax or other amount of money owed to the state or any of its political subdivisions because of a judgment, fine, permit violation, license assessment, defaulted workers' compensation premium, penalty or other assessment presently delinquent or due and required to be paid to the state or any of its political subdivisions, including any interest or additional penalties accrued thereon.

"Debtor" means any individual, corporation, partnership, association, Limited Liability Company or any other form or business association owing a debt to the state or any of its political subdivisions. "Political subdivision" means any county commission; municipality; county board of education; any instrumentality established by a county or municipality; any separate corporation or instrumentality established by one or more counties or municipalities, as permitted by law; or any public body charged by law with the performance of a government function or whose jurisdiction is coextensive with one or more counties or municipalities. "Related party" means a party, whether an individual, corporation, partnership, association, limited liability company or any other form or business association or other entity whatsoever, related to any vendor by blood, marriage, ownership or contract through which the party has a relationship of ownership or other interest with the vendor so that the party will actually or by effect receive or control a portion of the benefit, profit or other consideration from performance of a vendor contract with the party receiving an amount that meets or exceed five percent of the total contract amount.

EXCEPTION: The prohibition of this section does not apply where a vendor has contested any tax administered pursuant to chapter eleven of this code, workers' compensation premium, permit fee or environmental fee or assessment and the matter has not become final or where the vendor has entered into a payment plan or agreement and the vendor is not in default of any of the provisions of such plan or agreement.

Under penalty of law for false swearing ***(West Virginia Code*** §61-5-3), it is hereby certified that the vendor affirms and acknowledges the information in this affidavit and is in compliance with the requirements as stated.

WITNESS THE FOLLOWING SIGNATURE

Vendor's Name: _____

Authorized Signature:._____ Date: _____

State of_____

County of _____ , to-wit:

Taken, subscribed, and sworn to before me this day of _____, 20 __.

My Commission expires_____, 20__ .

AFFIX SEAL HERE **NOTORY PUBLIC** _____

MED-96

AGREEMENT ADDENDUM

In the event of conflict between this addendum and the agreement, this addendum shall control:

1. **DISPUTES** - Any references in the agreement to arbitration or to the jurisdiction of any court are hereby deleted. Disputes arising out of the agreement shall be presented to the West Virginia Court of Claims.

2. **HOLD HARMLESS** - Any clause requiring the Agency to indemnify or hold harmless any party is hereby deleted in its entirety.

3. **GOVERNING LAW** - The agreement shall be governed by the laws of the State of West Virginia. This provision replaces any references to any other State's governing law.

4. **TAXES** - Provisions in the agreement requiring the Agency to pay taxes are deleted. As a State entity, the Agency is exempt from Federal, State, and local taxes and will not pay taxes for any Vendor including individuals, nor will the Agency file any tax returns or reports on behalf of Vendor or any other party.

5. **PAYMENT** - Any references to prepayment are deleted. Payment will be in arrears.

6. **INTEREST** - Should the agreement include a provision for interest on late payments, the Agency agrees to pay the maximum legal rate under West Virginia law. All other references to interest or late charges are deleted.

7. **RECOUPMENT** - Any language in the agreement waiving the Agency's right to set-off, counterclaim, recoupment, or other defense is hereby deleted.

8. **FISCAL YEAR FUNDING** - Service performed under the agreement may be continued in succeeding fiscal years for the term of the agreement, contingent upon funds being appropriated by the Legislature or otherwise being available for this service. In the event funds are not appropriated or otherwise available for this service, the agreement shall terminate without penalty on June 30. After that date, the agreement becomes of no effect and is null and void. However, the Agency agrees to use its best efforts to have the amounts contemplated under the agreement included in its budget. Non-appropriation or non-funding shall not be considered an event of default.

9. **STATUTE OF LIMITATION** - Any clauses limiting the time in which the Agency may bring suit against the Vendor, lessor, individual, or any other party are deleted.

10. **SIMILAR SERVICES** - Any provisions limiting the Agency's right to obtain similar services or equipment in the event of default or non-funding during the term of the agreement are hereby deleted.

11. **ATTORNEY FEES** - The Agency recognizes an obligation to pay attorney's fees or costs only when assessed by a court of competent jurisdiction. Any other provision is invalid and considered null and void.

12. **ASSIGNMENT** - Notwithstanding any clause to the contrary, the Agency reserves the right to assign the agreement to another State of West Virginia agency, board or commission upon thirty (30) days written notice to the Vendor and Vendor shall obtain the written consent of Agency prior to assigning the agreement.

13. **LIMITATION OF LIABILITY** - The Agency, as a State entity, cannot agree to assume the potential liability of a Vendor. Accordingly, any provision limiting the Vendor's liability for direct damages to a certain dollar amount or to the amount of the agreement is hereby deleted. Limitations on special, incidental or consequential damages are acceptable. In addition, any limitation is null and void to the extent that it precludes any action for injury to persons or for damages to personal property.

14. **RIGHT TO TERMINATE** - Agency shall have the right to terminate the agreement upon thirty (30) days written notice to Vendor. Agency agrees to pay Vendor for services rendered or goods received prior to the effective date of termination.

15. **TERMINATION CHARGES** - Any provision requiring the Agency to pay a fixed amount or liquidated damages upon termination of the agreement is hereby deleted. The Agency may only agree to reimburse a Vendor for actual costs incurred or losses sustained during the current fiscal year due to wrongful termination by the Agency prior to the end of any current agreement term.

16. **RENEWAL** - Any reference to automatic renewal is hereby deleted. The agreement may be renewed only upon mutual written agreement of the parties.

17. **INSURANCE** - Any provision requiring the Agency to insure equipment or property of any kind and name the Vendor as beneficiary or as an additional insured is hereby deleted.

18. **RIGHT TO NOTICE** - Any provision for repossession of equipment without notice is hereby deleted. However, the Agency does recognize a right of repossession with notice.

19. **ACCELERATION** - Any reference to acceleration of payments in the event of default or non-funding is hereby deleted.

20. **CONFIDENTIALITY:** -Any provision regarding confidentiality of the terms and conditions of the agreement is hereby deleted. State contracts are public records under the West Virginia Freedom of Information Act.

21. **AMENDMENTS** - All amendments, modifications, alterations or changes to the agreement shall be in writing and signed by both parties. No amendment, modification, alteration or change may be made to this addendum without the express written approval of the Purchasing Division and the Attorney General.

ACCEPTED BY DHHR OFFICE OF PURCHASING:

Spending Unit: _____

Signed: _____

Title: _____

Date: _____

VENDOR

Company Name: _____

Signed: _____

Title: _____

Date: _____

Bureau for Medical Services

VENDOR PREFERENCE CERTIFICATE

Certification and application* is hereby made for Preference in accordance with ***West Virginia Code,*** §5A-3-37. (Does not apply to construction contracts). ***West Virginia Code,*** §5A-3-37, provides an opportunity for qualifying vendors to request (at the time of bid) preference for their residency status. Such preference is an evaluation method only and will be applied only to the cost bid in accordance with the ***West Virginia Code.*** This certificate for application is to be used to request such preference. The Purchasing Division will make the determination of the Resident Vendor Preference, if applicable.

1. Application is made for 2.5% resident vendor preference for the reason checked:

_____ Bidder is an individual resident vendor and has resided continuously in West Virginia for four (4) years immediately preceding the date of this certification; **or,**

_____ Bidder is a partnership, association or corporation resident vendor and has maintained its headquarters or principal place of business continuously in West Virginia for four (4) years immediately preceding the date of this certification; or 80% of the ownership interest of Bidder is held by another individual, partnership, association or corporation resident vendor who has maintained its headquarters or principal place of business continuously in West Virginia for four (4) years immediately preceding the date of this certification; **or,**

_____ Bidder is a nonresident vendor which has an affiliate or subsidiary which employs a minimum of one hundred state residents and which has maintained its headquarters or principal place of business within West Virginia continuously for the four (4) years immediately preceding the date of this certification; **or,**

2. Application is made for 2.5% resident vendor preference for the reason checked:

_____ Bidder is a resident vendor who certifies that, during the life of the contract, on average at least 75% of the employees working on the project being bid are residents of West Virginia who have resided in the state continuously for the two years immediately preceding submission of this bid; **or,**

3. Application is made for 2.5% resident vendor preference for the reason checked:

_____ Bidder is a nonresident vendor employing a minimum of one hundred state residents or is a nonresident vendor with an affiliate or subsidiary which maintains its headquarters or principal place of business within West Virginia employing a minimum of one hundred state residents who certifies that, during the life of the contract, on average at least 75% of the employees or Bidder's affiliate's or subsidiary's employees are residents of West Virginia who have resided in the state continuously for the two years immediately preceding submission of this bid; **or,**

4. Application is made for 5% resident vendor preference for the reason checked:

___ Bidder meets either the requirement of both subdivisions (1) and (2) or subdivision (1) and (3) as stated above; **or,**

5. Application is made for 3.5% resident vendor preference who is a veteran for the reason checked:

____ Bidder is an individual resident vendor who is a veteran of the United States armed forces, the reserves or the National Guard and has resided in West Virginia continuously for the four years immediately preceding the date on which the bid is submitted; **or,**

6. Application is made for 3.5% resident vendor preference who is a veteran for the reason checked:

___ Bidder is a resident vendor who is a veteran of the United States armed forces, the reserves or the National Guard, if, for purposes of producing or distributing the commodities or completing the project which is the subject of the vendor's bid and continuously over the entire term of the project, on average at least seventy-five percent of the vendor's employees are residents of West Virginia who have resided in the state continuously for the two immediately preceding years.

Bidder understands if the Secretary of Revenue determines that a Bidder receiving preference has failed to continue to meet the requirements for such preference, the Secretary may order the Director of Purchasing to: (a) reject the bid; or (b) assess a penalty against such Bidder in an amount not to exceed 5% of the bid amount and that such penalty will be paid to the contracting agency or deducted from any unpaid balance on the contract or purchase order.

By submission of this certificate, Bidder agrees to disclose any reasonably requested information to the Purchasing Division and authorizes the Department of Revenue to disclose to the Director of Purchasing appropriate information verifying that Bidder has paid the required business taxes, provided that such information does not contain the amounts of taxes paid nor any other information deemed by the Tax Commissioner to be confidential.

Under penalty of law for false swearing (West Virginia Code, §61 -5-3), Bidder hereby certifies that this certificate is true and accurate in all respects; and that if a contract is issued to Bidder and if anything contained within this certificate changes during the term of the contract, Bidder will notify the Purchasing Division in writing immediately.

Bidder: _____ **Signed:** _____

Date: _____ **Title:** _____

"Check any combination of preference consideration(s) indicated above, which you are entitled to receive

SPECIFICATIONS

1. **PURPOSE AND SCOPE:** The West Virginia Department of Health and Human Resources – Office of Purchasing is soliciting bids on behalf of the Bureau for Medical Services to establish a contract for the one time purchase of audit services for the West Virginia Disproportionate Share Hospital (DSH) program.

2. **DEFINITIONS:** The terms listed below shall have the meanings assigned to them below. Additional definitions can be found in section 2 of the General Terms and Conditions.

   2.1 "Desired Item" means the list of items identified in Section 3.

   2.2 "Bid Evaluation Page" means the page upon which Vendor should list its proposed price for the Desired Items in the manner requested by thereon. The Desired Item is either included on the last page of this RFQ or attached hereto as Exhibit A.

   2.3 "RFQ" means the official RFQ published by the West Virginia Department of Health and Human Resources – Office of Purchasing and identified as MED13004.

3. **GENERAL REQUIREMENTS:**

   3.1 Mandatory Desired Item Requirements: Desired Item must meet or exceed the mandatory requirements listed below.

   - Audit program that will ensure compliance with 42 U.S.C. Section 1923(j)(2). The Bureau will approve the contents of the audit program thirty (30) calendar days prior to the beginning of fieldwork. The engagement will include the performance of all audit procedures that the firm deems necessary for it to render an opinion and audit report as specified in this RFQ (whether conducted onsite at the hospitals' location or offsite at the firm's location). Travel and incidental costs shall be included in the all-inclusive, firm fixed price.

     Each quotation must describe how the Vendor will conduct the engagement to address the following:

     - Compliance with the requirements contained in the regulations and other guidance listed in Attachment 1, 3, 4, 5, and 6 (42 CFR Parts 447 and 455 and Centers for Medicare and Medicaid Services (CMS) guidance and requirements).

- The initial engagement covers "Medicaid State Plan Year" 2010 (July 1, 2009 – June 30, 2010). The regulations require that the engagement be completed by the last day of the Federal Fiscal Year (FFY) (September 30) to ensure final report issuance to CMS within ninety (90) days of completion (December 31). For example, CMS requires that the audit report for State Fiscal Year (SFY) 2010 (also known as the Medicaid State Plan Year) be completed by September 30, 2013. The Vendor must complete the engagement for SFY2010 by September 30, 2013 and must deliver a draft report to the Bureau by October 30, 2013 and the final reports to the Bureau by November 30, 2013. CMS has indicated no extensions allowed for the submission of reports.

The data necessary to complete the independent certified audit comes from the following source documents:

- The approved Medicaid State Plan for the State Plan rate year under audit. The approved Medicaid State Plan is available on the Bureau's website at http://www.dhhr.wv.gov/bms/Pages/default.aspx;
- State Medicaid Management Information System (MMIS) payment and utilization data (BMS provides this data in an electronic format);
- The Medicare 2552-96 cost report or subsequent Medicare defined hospital cost report (available from each hospital); and
- Hospital audited financial statements and hospital accounting records.

3.1.1 The Vendor's response must confirm that the independent certified audit report will address the six (6) verification items from 42 CFR §455.304 and satisfy all requirements as set forth in 42 CFR 447 and 455. Additionally, the response must include an acknowledgement of the Vendor's responsibility to compile the eighteen (18) data elements specified in the regulations for each hospital for each year audited and present that data in a separate schedule accompanying the audit report. The draft format of the schedule (a chart which lists each hospital included in the engagement and the eighteen (18) data elements for each hospital) must be included in the response; the final version shall include the amounts for each hospital for each data element.

3.1.1.1 The Vendor will issue a bound audit report that expresses an opinion on the six (6) verifications established in the final rule (see Attachment 1 and Attachment 3) and meets all requirements as set forth in 42 CFR 447 and 455.

3.1.1.2 The Vendor must provide the Bureau with an electronic version of the final report and four (4) hard copies (bound) and one (1) hard copy (bound) for each hospital included in the report by November 30, 2013. The Bureau will transmit the hard copy reports to each hospital.

3.1.1.3 The Vendor must be the primary audit firm and have the capacity, experience and training (i.e. the primary audit firm – not subcontracted) to provide the services and audit report specified in this RFQ. The Vendor must be a certified public accounting (CPA) firm in the United States. At a minimum, the quotation must describe; at least three (3) prior engagements of a similar nature the Vendor has performed to satisfy the requirements of the regulations specified in this RFQ; the Vendor CPA firm's organization and ownership; the Vendor's staff capacity by providing an organizational chart and accompanying resumes (limited to two (2) pages) for each individual bid for the project that specifies that the individual participated in the engagements that were provided as examples of prior engagements of a similar nature and describes the work the individual performed. The response must also specify how the firm will ensure that the engagement is accomplished within the due dates specified in section 3.1 of this RFQ.

3.1.1.4 The Vendor must meet the independence standards of governmental auditing standards as defined by the Comptroller General of the United States (available from the U.S. Government Accountability Office at http://www.gao.gov). At a minimum, the response must describe the CPA firm's policy that applies the Generally Accepted Government Auditing Standards (GAGAS) Conceptual Framework Approach to Independence, and that the policy incudes evaluation of independence for each audit engagement.

3.1.1.5 The Vendor must conduct the audit in accordance with Generally Accepted Governmental Audit Standards as defined by the Comptroller General of the United States (available from the U.S. Government Accountability Office at http://www.gao.gov and the American Institute of Certified Public Accountants (AICPA) Statements on Standards for Attestation Engagements (SSAE) (available from the AICPA at http://www.aicpa.org).

3.1.1.6 The Vendor's response must describe the CPA firm's processes and policies to ensure that staff is properly trained (i.e. satisfied professional requirements related to continuing professional education and GAGAS (Yellow Book) training), and has experience in performing audits in

accordance with these standards, specifically for government programs, by documenting this experience in the individual resumes as described in 3.1.1.3.

3.1.1.7 The Vendor must have independence from the Medicaid Agency and the hospitals they are to audit. The response must specifically describe services, if any, that it has provided to the hospitals listed in Attachment 2. Documentation of independence considerations related to the WV DSH Program and the hospitals listed in Attachment 2 shall be provided with the response.

3.1.1.8 The Vendor will have demonstrated ability by providing three (3) state references of DSH programs that the CPA firm audited in accordance with the regulations cited in this RFQ, a copy of the audit report produced, documentation that the audit reports were accepted by CMS, documentation that the audit engagements were completed by September 30 of the applicable year, and documentation that the audit reports were delivered to the state for filing with CMS prior to December 30 of the applicable year to satisfy the requirements of the regulations cited herein.

3.1.1.9 The Vendor will conduct an exit conference with the DHHR and Bureau representatives once a preliminary typed draft of the required engagement report has been accepted by BMS. The exit conference will be via Web conference. The response must describe how the firm will design the engagement to ensure that the delivery of the typed draft of the required engagement report allows for review and acceptance by BMS, and scheduling of the exit conference will be completed in time, and the timing of the exit conference must be scheduled to allow adequate time to meet the applicable CMS deadlines in section 3.1. The firm shall agree to include Bureau responses in the final bound report when it is issued.

3.1.2 The Vendor's engagement shall provide the Bureau and applicable DSH hospitals an opportunity to provide a written response to management letter comments. The firm must describe how it will structure the engagement to provide for this activity.

3.1.3 The Vendor will provide a work plan demonstrating an understanding of the overall engagement and services to be provided by providing;

3.1.3.1 Timeline showing how the Vendor will meet project deliverables referenced in section 3.1 including timeframes for completion of audit procedures and issuance of the final bound audit report and required copies.

3.1.3.2 Understanding of Federal DSH audit requirements per 42CFR Parts 447 and 455 and CMS guidance (see Attachment 1, 3, 4, 5, and 6).

3.1.3.3 Compliance with General DSH Audit and Reporting Protocol – see Attachment 4.

3.1.3.4 Additional guidance issued by CMS as referenced in Attachment 5 and 6.

3.1.3.5 Audit program and a description of the level of staff to be assigned to the engagement, as well as the level of staff to be assigned to complete each section of the audit program. Specify the number of hours for each staff level assigned to the overall engagement and indicate as a percentage. The planned use of specialists or subcontractors must also be specified (the Bureau reserves the right to approve all use of subcontractors).

3.1.3.6 Draft report package that includes the draft opinion letter format and supporting schedules.

3.1.3.7 Provide resumes of staff assigned to the project. Resumes must also include licenses, credentials and describe each individual's experience on the three engagements submitted in accordance with 3.1.1.3 and specify that the work they will perform on this audit engagement is similar to the work on prior similar engagements. Resumes shall be limited to two (2) pages.

3.1.4 The Vendor will provide a training plan to provide training and assistance regarding DSH audit and reporting compliance which describes:

3.1.4.1 The Vendor's experience and qualifications to provide such training by providing a description of similar prior trainings and the outcomes of the trainings.

3.1.4.2 Methods and means that will be used to ensure that the objectives of the training are achieved.

3.1.4.3 Sample training materials used in at least three similar trainings.

3.1.4.4 Training at least two months prior to the beginning of fieldwork, and within six weeks of any new regulations or CMS guidance/interpretations issued or regulation, guidance or interpretation changes.

3.1.4.5 Provider training must be provided on-site for the initial training that occurs after contract award. Training related to subsequent State Plan Review years covered in the scope of this contract and subsequent release of federal guidance or regulations by CMS will be provided via webinars.

3.1.5 Externally Driven Changes

3.1.5.1 The Vendor shall agree to make all adjustments to audit procedures and reporting that impact the scope of the engagement upon future issuance of guidance by CMS, regardless of the timing of such issuance.

3.1.5.2 The Vendor shall provide all administrative, expert witness and other services necessary to represent the Bureau in the event of an audit, provider appeals or receipt of questions related to the work product of the Vendor. These services will be provided until all litigation; claims and or audit findings are resolved with the Federal government regardless of whether the timing is within the contract period or after the contract period has expired

3.1.5.3 The Vendor will provide additional services to comply with externally driven changes to BMS programs and requirements, including any State or Federal laws, rules, and regulations. Additional services shall be bid as an all-inclusive hourly rate and shall require Bureau approval of a Statement of Work (SOW) and submission of a related Cost Estimate.

4. CONTRACT AWARD:

4.1 Contract Award: The Contract is intended to provide Agencies with a purchase price for the Desired Items. The Contract shall be awarded to the Vendor that provides the Desired Items meeting the required specifications for the lowest overall total cost as shown on the Pricing Pages.

4.2 Bid Evaluation Page: Vendor should complete the Bid Evaluation Page by completing Exhibit A. Vendor should complete the Bid Evaluation Page in full as failure to complete the Bid Evaluation Page in its entirety may result in Vendor's bid being disqualified.

Notwithstanding the foregoing, the West Virginia Department of Health and Human Resources – Office of Purchasing may correct errors as it deems appropriate. Vendor should type or electronically enter the information into the Bid Evaluation Page to prevent errors in the evaluation.

5. PAYMENT:

5.1 Payment: Vendor shall accept payment in accordance with the payment procedures of the State of West Virginia. Methods of acceptable payment must include the West Virginia Purchasing Card. Payment in advance is not permitted under this Contract.

6. DELIVERY AND RETURN:

6.1 Shipment and Delivery: Vendor shall ship the Desired Items immediately after being awarded this Contract and receiving a purchase order or notice to proceed. Vendor shall deliver the Desired Items by the deadlines specified in the solicitation after receiving a purchase order or notice to proceed. Desired Items must be delivered to Agency at 350 Capitol Street – Room 251, Charleston WV 25301.

6.2 Late Delivery: The Agency placing the order under this Contract must be notified in writing if the shipment of the Desired Items will be delayed for any reason. Any delay in delivery that could cause harm to an Agency will be grounds for cancellation of the Contract, and/or obtaining the Desired Items from a third party.

Any Agency seeking to obtain the Desired Items from a third party under this provision must first obtain approval of the Office of Purchasing.

6.3 Delivery Payment/Risk of Loss: Vendor shall deliver the Desired Items F.O.B. destination to the Agency's location.

6.4 Return of Unacceptable Items: If the Agency deems the Desired Items to be unacceptable, the Desired Items shall be returned to Vendor at Vendor's expense and with no restocking charge. Vendor shall either make arrangements for the return within five (5) days of being notified that items are unacceptable, or permit the Agency to arrange for the return and reimburse Agency for delivery expenses. If the original packaging cannot be utilized for the return, Vendor will supply the

Agency with appropriate return packaging upon request. All returns of unacceptable items shall be F.O.B. the Agency's location. The returned product shall either be replaced, or the Agency shall receive a full credit or refund for the purchase price, at the Agency's discretion.

6.5 Return Due to Agency Error: Items ordered in error by the Agency will be returned for credit within 30 days of receipt, F.O.B. Vendor's location. Vendor shall not charge a restocking fee if returned products are in a resalable condition. Items shall be deemed to be in a resalable condition if they are unused and in the original packaging. Any restocking fee for items not in a resalable condition shall be the lower of the Vendor's customary restocking fee or 5% of the total invoiced value of the returned items.

Attachment 1:

Centers for Medicare & Medicaid Services
42 CFR Parts 447 and 455
Medicaid Program; Disproportionate Share Hospital Payments; Final Rule

Federal Register

Friday,
December 19, 2008

Part III

Department of Health and Human Services

Centers for Medicare & Medicaid Services

42 CFR Parts 447 and 455
Medicaid Program; Disproportionate Share Hospital Payments; Final Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 447 and 455

[CMS–2198–F]

RIN 0938–AN09

Medicaid Program; Disproportionate Share Hospital Payments

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

ACTION: Final rule.

SUMMARY: This final rule sets forth the data elements necessary to comply with the requirements of Section 1923(j) of the Social Security Act (Act) related to auditing and reporting of disproportionate share hospital payments under State Medicaid programs. These requirements were added by Section 1001(d) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).

DATES: *Effective Date:* This rule is effective on January 19, 2009.

FOR FURTHER INFORMATION CONTACT: Venesa Day, (410) 786–8281; Rory Howe, (410) 786–4878; and Rob Weaver, (410) 786–5914.

SUPPLEMENTARY INFORMATION:

I. Background

Title XIX of the Social Security Act (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 such disproportionate share hospital (DSH) payments, including aggregate annual state-specific limits on Federal financial participation under Section 1923(f), and hospital-specific limits on DSH payments under Section 1923(g). Under those hospital specific limits, a hospital's DSH payments may not exceed the costs incurred by that hospital in furnishing services during the year to Medicaid patients and the uninsured, less other Medicaid payments made to the hospital, and payments made by uninsured patients ("uncompensated care costs"). In addition, Section 1923(a)(2)(D) requires States to provide an annual report to the Secretary describing the payment adjustments made to each disproportionate share hospital.

Section 1001(d) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108–173, enacted on December 8, 2003) added Section 1923(j) to the Act to require States to report additional information about their DSH programs. Section 1923(j)(1) of the Act requires States to submit an annual report that includes the following:

- Identification of each DSH facility that received a DSH payment under the State's Medicaid program in the preceding fiscal year and the amount of DSH payments paid to that hospital in the same year.
- Such other information as the Secretary of Health and Human Services determines necessary to ensure the appropriateness of DSH payments.

Section 1923(j)(2) of the Act also requires States to have their DSH payment programs independently audited and to submit the independent certified audit annually to the Secretary. The certified independent audit must verify:

- The extent to which hospitals in the State have reduced uncompensated care costs to reflect the total amount of claimed expenditures made under Section 1923 of the Act.
- DSH payments to each hospital comply with the applicable hospital-specific DSH payment limit.
- Only the uncompensated care 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 limits.
- The State included all Medicaid payments, including supplemental payments, in the calculation of such hospital-specific limits.
- The State has separately documented and retained a record of all its costs under the Medicaid program, claimed expenditures under the Medicaid program, uninsured costs in determining payment adjustments under Section 1923 of the Act, and any payments made on behalf of the uninsured from payment adjustments under Section 1923 of the Act.

In addition to these reporting requirements, under Section 1923(j) of the Act, Federal matching payments are contingent upon a State's submission of the annual DSH report and independent certified audit.

II. Summary of the Proposed Regulations

On August 26, 2005, we published in the **Federal Register** (70 FR 50262–50268) a notice of proposed rulemaking implementing the reporting and auditing requirements for State Disproportionate Share Hospital payments. In this notice of proposed rulemaking, we proposed modifying the DSH reporting requirements in Federal regulations at 42 CFR 447 by providing the following changes to our regulations:

1. Reporting Requirements

To implement the reporting requirements in Section 1923(j)(1) of the Act, we proposed to modify the DSH reporting requirements in Federal regulations at 42 CFR 447.

- We proposed to add a new paragraph (c) to the reporting requirements in § 447.299.
- We proposed to redesignate the documentation requirements in paragraph (c) as paragraph (d) and redesignate the deferrals and disallowances information in paragraph (d) as paragraph (e), respectively.
- We proposed a list of information to reflect the data elements necessary to ensure that DSH payments are appropriate such that each qualifying hospital receives no more in DSH payments than the amount permitted under Section 1923(g) of the act.
- We proposed that paragraph (c) would require each State receiving an allotment under Section 1923(f) of the Act, beginning with the first full State fiscal year (SFY) immediately after the enactment of Section 1001(d) of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) and each year thereafter, to report to us the list of information detailed in an Reporting form, which was published in the September 23, 2005 correction notice entitled "Medicaid Programs; Disproportionate Share Hospital Payments".
- We proposed that States will need to consider a Section 1011 payment when determining the hospital's DSH limit, because the total DSH payments should not exceed the total amount of uncompensated care at the hospital.
- The information supplied on this spreadsheet would satisfy the requirements under Sections 1923(a)(2)(D) and 1923(j)(1) of the Act.

2. Audit Requirements

We explained the statute's requirement for States to verify their methodology for computing the hospital specific DSH limit and the DSH

payments made to hospitals. As required by Section 1923(j)(2) of the Act, these five items identified in statute would provide independent verification that State Medicaid DSH payments comply with the hospital-specific DSH limit in Section 1923(g) of the Act, and that such limits are accurately computed.

- In § 455.201, we proposed that "SFY" stands for State fiscal year.
- We proposed to define that an "independent audit" means an audit conducted according to the standards specified in the generally accepted government auditing standards issued by the Comptroller General of the United States.
- We proposed adding a new § 455.204(a) to reflect Section 1923(j) of the Act's requirement that each State must submit annually the independent certified audit of its DSH program as a condition for receiving Federal payments under Section 1903(a)(1) and 1923 of the Act.
- We proposed to add a new § 455.204(b) to reflect the requirement that States must obtain an independent certified audit, beginning with an audit of its State fiscal year 2005 DSH program.
- We proposed a submission requirement within 1 year of the independent certified audit.
- We proposed that in the audit report, the auditor must verify whether the State's method of computing the hospital-specific DSH limit and the DSH payments made to the hospital comply with the five items required by Section 1923(j)(2) of the Act.

III. Discussion of Public Comments

On August 26, 2005, we set forth a proposed rule implementing the reporting and auditing requirements for State disproportionate share hospital payments (DSH). In this notice of proposed rulemaking, we proposed several modifications to the DSH reporting requirements and detailed the statutory auditing requirements for States to verify their methodology for computing the hospital-specific DSH limit to ensure that DSH payments made to eligible hospitals do not exceed such limits.

We received 119 timely public comments, in response to the August 26, 2005, proposed rule. The comments came from a variety of correspondents, including professional associations, national and State organizations, physicians, hospitals, advocacy groups, State Medicaid programs, State Legislators, and members of the Congress. The following is a summary of the comments received and our response to those comments.

A. General Comments on Auditing and Reporting Provisions

We received the following general comments regarding the proposed regulation:

Comment: Many commenters believe the proposed regulation exceeds the Congressional intent of the statutory authority of the MMA, makes substantive interpretations and changes to longstanding DSH policy not required by MMA and attempts to establish new policy.

Response: The statutory authority under MMA instructed States to report and audit specific payments and specific costs. Section 1923(j)(1)(B) of the Act specifically delegated to the Secretary authority to require reporting of information "necessary to ensure the appropriateness of payment adjustments made under this Section." These regulations require reporting of data elements that are specifically related to the appropriateness of DSH payments, and thus are consistent with that statutory provision. The regulations provide States with uniform instructions that contain detailed identification of the necessary data elements. The audit requirements also specified in Section 1923(j)(2) of the Act, and these regulations specifically track the statutory requirements.

Comment: Many commenters are concerned that CMS has used the MMA provisions, which only relate to reporting and auditing, to dramatically change the financing of the Medicaid DSH program; this change would have serious implications for hospitals that care for the low-income and uninsured.

Response: Neither the statute nor the implementing regulation addresses the financing of DSH payments. The statutory authority under MMA instructed States to report and audit specific payments and the underlying calculations. While it could be that this information discloses impermissible payments (or "financing"), this does not reflect a change in the standards for such payments. Instead the information will ensure that payments conform with existing applicable law.

Comment: Several commenters noted that the proposed rule purports to implement statutory reporting and audit requirements that do not alter any of the substantive standards regarding the calculation of costs under the hospital-specific DSH cap. They asserted that it would be completely improper for CMS to employ preamble language, or include in the rule provisions that would alter substantive standards under the auspices of new statutory reporting requirements.

Response: The provisions of this rule do not alter the fundamental statutory requirements to calculate DSH hospital-specific uncompensated care costs, and audit such calculations, in order to demonstrate that payments are proper. This rulemaking sets forth reporting requirements to ensure uniformity in the understanding and implementation of these requirements. By doing so, the rule will ensure that the basis for DSH payments is clear, including the required hospital-specific uncompensated care cost calculations, and set forth the necessary elements for an independent audit of those cost calculations and payments following the statute as amended by the MMA.

Comment: A few commenters expressed disagreement with the manner in which the proposed regulation would employ audits to determine whether States are making Medicaid DSH payments in appropriate amounts. These commenters argued that audits should not limit State discretion in the manner in which DSH payments are calculated. These commenters objected to the proposed requirements that auditors determine whether DSH is being calculated "correctly" when there has never been a single, true, definitive definition of exactly what "correct" means. In other words, the commenters argued that the regulation proposes counting on auditors to help impose a standard that does not currently exist.

Response: We disagree that the calculations involved in applying the hospital-specific DSH limits are discretionary. There have been clear and longstanding standards for calculating the costs of hospital services that apply to the calculation of hospital-specific DSH limits. The statutory authority under MMA instructed States to report and audit specific payments and specific costs to ensure compliance with those standards.

The applicable standards are based on existing statutes, regulations, and interpretive guidance. In 1993, Congress imposed hospital-specific limitations on the level of DSH payments to which qualifying hospitals were entitled. Section 1923(g)(1)(A) specifies that DSH payments cannot exceed, "the costs incurred during the year of furnishing hospital services (as determined by the Secretary and net of payments under this title, other than under this Section, and by uninsured patients * * *)". In 1994, CMS issued guidance that clarified that the 1993 hospital-specific "cost" limit includes both inpatient and outpatient hospital services for Medicaid individuals and individuals

with no source of third party coverage. Moreover, the calculation of hospital costs is subject to longstanding cost principles contained in Office of Management and Budget Circulars, including Circular A–110, and, to the extent not addressed in those Circulars, in Generally Accepted Accounting Principles (GAAP). In addition, over the years CMS has addressed hospital cost accounting in considerable detail in the Medicare program, and has developed cost reporting forms and procedures that offer further guidance on these issues.

Comment: A few commenters stated that, to the extent that CMS retains substantive changes to DSH policy in this regulation, CMS should acknowledge that this regulation does more than merely implement reporting and auditing requirements against existing standards.

Response: This regulation does not alter any of the substantive standards regarding the calculation of hospital costs, but requires that auditors apply those standards in determining the hospital-specific DSH limit. The preamble and the regulation set forth reporting requirements to ensure that the basis for DSH payments is clear, including the required hospital-specific uncompensated care cost calculations, and set forth the necessary elements for an independent audit of those cost calculations and payments.

Comment: Several commenters noted that States have implemented and carried out their DSH programs pursuant to methodologies set forth in CMS-approved Medicaid State plan amendments which were developed consistent with the DSH statute that provides States the flexibility to adopt procedures and methodologies tailored to each State's health care delivery system. The commenters asserted that the proposed rule would impose new substantive requirements that would be implemented through third-party auditors applying standards that are at odds with existing State plan provisions. They asserted that the approved Medicaid plan in each Medicaid State plan should provide the substantive basis for the independent audits and reports required under Section 1923(j). Because CMS approved the Medicaid State plan provisions and has not implemented the statutory process that would be required to render them invalid, the commenters stated that the Medicaid State plans should be deemed to reflect current Federal policy on the implementation of the Medicaid DSH program and be the standard by which FFP is available for State Medicaid expenditures.

Response: In reviewing State DSH payments, auditors must first determine whether the DSH payments were initially calculated using the methodology authorized by the approved Medicaid State plan. These Medicaid State plans, in part, articulate the methods and standards by which States set payment rates. Section 4.19–A of the Medicaid State plan includes the methodologies States utilize to make Medicaid DSH payments. The statutory hospital-specific limit, however, overlays that methodology because it is determined by actual uncompensated costs of inpatient and outpatient hospital services. States typically include a provision within the Medicaid State plan that DSH payments will not exceed each qualifying hospital's DSH limit.

The DSH payment methodologies contained in Section 4.19–A of the Medicaid State plan do not specifically identify the cost components included in the hospital-specific DSH limits but are governed by longstanding principles set forth in statutes, regulations, and agency guidance.

While CMS recognizes that States must use prospective estimates to determine DSH payments in a given Medicaid State plan rate year, the audits required by the MMA are statutorily required to verify the extent to which such estimates are reflective of the actual costs and that resultant payments do not exceed such cost limitations imposed by Congress.

Comment: Several commenters noted that the proposed rule would establish DSH policy that reaches beyond the reporting and audit requirements outlined in Section 1001(d). They cited the example that, if a State fails to comply with the reporting and auditing requirements, CMS proposes to impose a penalty that would result in the loss of Federal matching Medicaid dollars.

Response: Section 1923(j) of the Act very clearly stipulates that Medicaid DSH payments are conditioned upon the submission of the annual report and independent certified audit is required. However, with respect to requiring recovery of any overpayments, the regulation does not impose an immediate penalty that would result in the loss of Federal matching dollars. As described in subsequent responses to comments specific to the auditing component of the regulation, because a trial period will be required for auditors to refine audit methodologies, findings from Medicaid State plan rate year 2005 through 2010 will be used only for the purpose of determining prospective hospital-specific cost limits and the actual DSH payments associated with a particular year.

Beginning in Medicaid State plan rate year 2011, to the extent that audit findings demonstrate that DSH payments exceed the documented hospital-specific cost limits, CMS will regard them as representing discovery of overpayments to providers that, pursuant to 42 CFR Part 433, Subpart F, triggers the return of the Federal share to the Federal government (unless the DSH payments are redistributed by the State to other qualifying hospitals as an integral part of the audit process). This is not a "penalty" but instead reflects adjustment of an overpayment that was not consistent with Federal statutory limits. We note that, to the extent that States wish to redistribute DSH payments that exceed hospital-specific limits, the Federally approved Medicaid State plan must reflect that payment policy.

Comment: A few commenters said there are existing administrative procedures for determining a Medicaid State plan's compliance with Federal Medicaid law, which include a notice and hearing process. Nothing in Section 1923 or its legislative history suggests that Congress intended to circumvent these longstanding procedures through the audit and reporting requirements. Therefore, any attempt to do so in the guise of these implementing regulations would be invalid.

Response: The MMA independent audit procedures establish a process for discovery of DSH overpayments that trigger existing responsibilities for States to refund the Federal share of Medicaid overpayments to providers. The audits provide information that will identify DSH payments that exceed the amounts permitted under Section 1923(g)(1) of the Act and incorporated by reference into approved State plans. This information, in the form of an independent certified audit obtained by the State, will result in discovery of DSH overpayments and will trigger requirements to refund the Federal share of those overpayments, pursuant to existing requirements at 42 CFR Part 433, Subpart F. States that do not refund the Federal share of overpayments will be subject to disallowance of claims for Federal funds, and will have notice and an opportunity for a hearing through the Medicaid disallowance process. We believe this is consistent with the apparent purpose of the audit requirement to ensure the financial integrity of State DSH payments, and to ensure that DSH payments are targeted at addressing the burdens faced by hospitals which serve a

disproportionate share of low income patients.

Comment: Many commenters said that the Medicaid DSH program was designed to recognize the financial burden borne by those hospitals that take care of a disproportionate number of low income and uninsured individuals, and to provide financial assistance essential for these safety net providers to continue to take care of patients. Medicaid DSH funds are critical to the future viability of their hospitals. They were concerned that any new policy interpretation that results in substantially lower DSH payments or affects prior year DSH payments will have a significant financial impact on (safety net) hospitals, and will threaten their ability to continue to serve the community. Because of the negative impact on hospitals and on the patients they serve, the commenters strongly urge CMS to rethink its approach in this proposed rule. A few commenters stated that changing the Federal position on this matter could cause significant financial problems for State Medicaid programs.

Response: This rule does not impose any new restrictions on DSH payments. The statute calls for reporting and auditing of DSH payments, to ensure that such payments comply with existing statutory requirements limitations. This rule does not restrict the aggregate DSH funding that is available, nor does it effect DSH payments that comply with all statutory requirements. Consequently, there should be no effect on DSH payments that have been properly made to hospitals to account for the burden of treating a disproportionate share of low income patients.

Comment: Several commenters referenced the 1994 guidance to State Medicaid Directors in which CMS granted flexibility in allowing a State to use the definition of allowable costs in its State Medicaid plan or any other definition as long as the costs determined under such a definition do not exceed the amounts that would be allowable under the Medicare principles of cost reimbursement. They argued that this pronouncement was consistent with the principle that Medicaid is a Federal-State partnership and should be continued. Since this is a Medicaid DSH program, they assert that the State should be permitted to determine the definition of allowable costs as either not exceeding amounts allowable under Medicare principles of cost reimbursement or amounts that would be consistent with the State's existing Medicaid program. They asked that the rule reaffirm State flexibility in defining allowable costs.

Response: States have considerable discretion to determine allowable inpatient and outpatient costs when determining payment rates under their Medicaid State plan, but Section 1923(g)(1) of the Act provides for a Federal limitation based on costs that must be calculated in accordance with Federal accounting standards. In accordance with this principle, the 1994 guidance provided State flexibility to define Medicaid costs for purposes of setting Medicaid payment rates. But this flexibility does not apply to calculation of hospital-specific DSH limits to the extent that State-defined costs exceed those permitted under Medicare cost principles.

Moreover, the hospital-specific limit is based on the costs incurred for furnishing "hospital services" and does not include costs incurred for services that are outside either the State or Federal definition of inpatient or outpatient hospital services. While States have some flexibility to define the scope of "hospital services," States must use consistent definitions of "hospital services." Hospitals may engage in any number of activities, or may furnish practitioner or other services to patients, that are not within the scope of "hospital services." A State cannot include in calculating the hospital-specific DSH limit cost of services that are not defined under its Medicaid State plan as a Medicaid inpatient or outpatient hospital service.

Comment: Numerous commenters said the proposed rule violates Administrative Procedure's Act rulemaking requirements because there was inadequate notice and opportunity for public comment on the proposed policy to limit hospital costs includable in the Medicaid DSH calculation. The commenters stated this is a proposed regulation for a reporting requirement only and that the cited statutory authority for the proposed rule has no bearing on allowability of costs in DSH calculation. These commenters stated the rule would substantively change longstanding DSH policy without appropriately calling for direct public comment.

Response: CMS published the Notice of Public Rule Making on August 26, 2005. As part of this publication, a 60 day comment period was provided. CMS received and considered numerous comments, as discussed in this preamble. Through this process, rulemaking requirements under the Administrative Procedure Act have been met. Moreover, the rule does not substantively change the standards for DSH payments, or for the review of hospital-specific limits on such payments. Even if the rule did make changes to those standards, however, CMS has followed the appropriate rulemaking procedures for such changes. Fundamentally, this rule implements statutory requirements to review and audit the calculation of DSH hospital-specific limits, including only the costs of those hospital services that are specified in the statute, and accounting for such costs consistently with existing applicable cost accounting principles.

Comment: One commenter further indicated that this is not just an issue of notice and comment rulemaking as required under the Administrative Procedure Act, it is an issue of Federal-State comity. The commenter asserted that the requirements contained in the proposed rule are not consistent with Supreme Court decisions providing that, if Congress intends to impose a condition on the grant of Federal moneys, it must do so unambiguously.

Response: The statute expressly requires that States report and audit DSH payments consistent with existing statutory limitations on such payments; this rule simply defines the nature and scope of these reporting and audit requirements. These requirements are related to ensuring Medicaid program integrity and transparency by providing information to identify improper payments, and the cost of meeting those requirements may be claimed as an administrative cost of the Medicaid program, eligible for Federal matching funding. As such, the statutory requirements are not new substantive responsibilities, but are part of existing State responsibilities to administer State Medicaid programs. Moreover, the Medicaid statute expressly requires the Secretary to identify necessary reporting requirements and the Secretary has oversight authority to ensure compliance with the statutory audit requirements. This rule provides detailed identification of the data elements necessary to comply with such reporting and auditing requirements expressly contained in statute. As an interpretation and implementation of clear statutory responsibilities, this rule is consistent with the cited Supreme Court decisions.

B. Reporting

1. Retroactivity

Comment: One commenter stated that their State would need to make several regulation changes that would need to be retroactive to July 1, 2005. The State

currently does not have a procedure to change regulations retroactively.

Response: CMS does not agree that States would need to retroactively change their programs to comply with the audit and reporting requirements associated with Medicaid State plan rate year 2005. The audit and reporting requirements discussed in this regulation can be met through prospective actions by States, and thus do not have retroactive effect. While the information disclosed by the audit and reporting requirements may reveal the need for retroactive adjustments to account for payments that are improper, this is no different from any other audit situation. Moreover, in order to ensure a period for developing and refining audit practices, we are providing for a transition period through Medicaid State plan rate year 2010, before audit results will be given weight other than in making prospective estimates of hospital costs for the purposes of ongoing DSH payments.

Comment: Many commenters stated that applying the proposed rule's requirements to dates of service prior to State fiscal year (SFY) 2005 would represent an undue administrative burden and a hardship for States and hospitals. Several commenters stated that it is unreasonable to expect that States are going to have readily available to them for SFY 2005, the data elements that CMS is just now requiring to be reported under this proposal. Applying the changes to the reporting requirements to SFY 2005 is a retroactive application and puts the States in the position of struggling to retrieve data that was not collected during SFY 2005. This would ultimately be to the detriment of the providers if the States are unable to capture all of the uncompensated care costs when they submit their reports. Many other commenters suggested all reporting and auditing requirements be prospective. In addition, they suggested linking the new reporting and auditing requirements to the first State fiscal year beginning after the finalization of the rule, no earlier than SFY 2006, with an audit being no earlier than 2 years later.

A few commenters stated that the effective date of State Fiscal Year (SFY) 2005 would not give hospitals time needed to modify their procedures to comply with State instructions for reporting made pursuant to the final regulations.

Response: We have modified the regulation to address concerns regarding the inability to complete the audit one year from the end of SFY 2005. The final regulation provides at 447.204(b) that:

1. The Medicaid State plan rate year 2005, rather than State fiscal year 2005, is the first time period subject to the audit. The basis for this modification is recognition of varying fiscal periods between hospitals and States. The Medicaid State plan rate year is the one uniform time period under which all States estimate uncompensated costs in order to make DSH payments under the approved Medicaid State plan.

2. In recognition of timing issues related to initiating the audit process, States may concurrently complete the Medicaid State plan rate year 2005 and 2006 audits by no later than September 30, 2009.

3. Each subsequent audit beginning with Medicaid State plan rate year 2007 must be completed by the last day of the Federal fiscal year (FFY), September 30, ending three years from the Medicaid State plan rate year under audit. This means that the 2007 Medicaid State plan rate year must be audited by September 30, 2010.

4. Each audit report must be submitted to CMS within 90 days of the completion of the audit. The report associated with Medicaid State plan rate years 2005 and 2006 are due no later than December 31, 2009. The 2007 Medicaid State plan rate year audit report must be submitted to CMS by December 31, 2010.

In addition, we have added a transition period at 447.204(d) to reflect concerns that auditing techniques may need to be reviewed and refined. Findings of the Medicaid State plan rate year audits through 2010 will not be given weight other than for purposes of prospective Medicaid State plan rate year uncompensated care cost estimates and associated DSH payments. This means that, starting in Medicaid State plan rate year 2011, such findings should be used in the calculation of prospective estimates related to DSH payments.

We are also making clear that DSH payments that, after the regulatory transition period, are found in the audit process to exceed the hospital-specific cost limits are provider overpayments that must be promptly returned to the Federal Government or redistributed by States to other qualifying hospitals. (Such redistribution authorities must be articulated in the Federally approved Medicaid State plan.) After the transition period to ensure the accuracy and reliability of audit techniques, such audit findings represent discovery of an overpayment under existing regulations at 42 CFR Part 433, Subpart F. We note that the regulatory transition provision is not intended to preclude review of DSH payments and discovery of overpayments prior to Medicaid State plan rate year 2011, to the extent that such review is independent of the State audit process.

Comment: One commenter noted that the proposed reporting requirements do not provide for any option to request an extension for the submission of the information or audit.

Response: As indicated in the response above, we have extended the audit and report submission date in the regulation. These extended time frames are detailed in a prior response and the regulation has been revised accordingly. Based on the revisions, the time frames are sufficiently long that there should be no need for extensions beyond the revised time frames. In the event of a natural disaster, or other incident beyond a State's control, we would consider providing relief in the context of a demonstration project that addresses the overall circumstances of the State.

Comment: Many commenters noted that the NPRM applies these new changes to retroactively FY 2005 when most DSH plans are already in place. Medicaid State Plans, regulations, and/or statutes will need to be amended to reflect the new reporting and audit requirements, which are retroactive to 7/1/05.

Response: CMS does not agree that States would need to retroactively change regulations to comply with the audit and reporting requirements associated with Medicaid State plan rate year 2005. In the audit process, Medicaid State plan DSH payments in the State plan rate year 2005 will be reviewed against uncompensated care costs during that same period (for example, OBRA 93 hospital-specific limits), which is consistent with the existing statutory provisions of Section 1923(g)(1). States will not need to retroactively modify their Medicaid State plans to comply with this regulation. The DSH reimbursement methodologies contained in Medicaid State plans articulate the methods by which States make DSH payments and already contain assurances that such DSH reimbursement methodologies will not exceed the OBRA 93 hospital-specific DSH limits. Typically, States currently rely on unaudited surveys to estimate uncompensated care in eligible hospitals, and this regulation would simply require reconciliation based on statutory cost limits using a more accurate audit methodology.

Under this regulation, the State DSH audit and report will use actual cost and payment data beginning with the Medicaid State plan rate year 2005 to ensure that DSH payments in the

approved Medicaid State plan did not exceed DSH eligible costs in hospitals receiving DSH payments. As noted above, to allow a period to develop and refine audit techniques, we also have included a transition period before audit results will be directly used to identify provider overpayments.

Comment: One commenter stated that the proposed reporting requirements refer to submission timing on two different pages, which are inconsistent with each other. On Page 50264 of the **Federal Register** under the Audit Requirements Section, it states, "We are proposing a submission requirement within 1 year of the independent certified audit." On Page 50268 of the **Federal Register** under the List of Subjects Section, where the proposed revisions to Section 455.204(b) are indicated, it states, "Timing. Beginning with State fiscal year (SFY) 2005, a State must submit to CMS an independent certified audit report no later than 1 year after the completion of each State's fiscal year."

Response: The regulation has been modified to achieve consistent audit and reporting time frames. Generally, audits will examine prior period DSH payments and such audit must be completed by the last day of the FFY ending three years from the Medicaid State plan rate year under audit. Reports of the audit will be due within 90 days of completion of the audit. A special transition period is provided for Medicaid State plan rate year 2005 and 2006 audits. Further detail of audit and reporting are described in other responses to comments.

2. Effect of Lag in Medicaid Claims

Comment: Several commenters noted that there is already a requirement for States to indicate the regular Medicaid rate payments paid to the hospital for the SFY as part of the Medicaid claims information provided to CMS through the Medicaid Statistical Information System (MSIS). Claims may be submitted to the State for payment up to one year after the date of service. Therefore, payments made by the State for claims with dates of service in the SFY may be submitted up to a year after the service date by the hospital. The payment information would not be available before 12 months after the SFY at a minimum. Obtaining the amount paid by the State for the SFY being reported is not possible by the end of the SFY.

Response: Based on the modifications to the audit and reporting deadlines, the existing requirement at 42 CFR 447.45(d) for provider claims to be filed within a year from the date of service and promptly paid by the State, and the existing two-year timely claim filing requirement at 45 CFR 95.7, there should not be a significant adjustment to Medicaid payments that would warrant a corrected report. To the extent that such an adjustment to Medicaid payments occurs and States claim Federal matching dollars (or return Federal matching dollars) as a prior period adjustment, States should correct the audit and report by indicating post-audit adjustments to Medicaid and DSH payments (or uncompensated care costs if Medicaid payment adjustments affect the Medicaid shortfall).

States must consider post-audit adjustments, as information about them becomes available, to the extent that the State's DSH methodology involves prospective estimates of uncompensated care, at least beginning in Medicaid State plan rate year 2011. Similarly, such adjustments must be reported in the quarter the underlying claims were paid, and must be considered to determine if there were overpayments, beginning with Medicaid State plan rate year 2011 (although in some cases, the State plan may authorize the State to redistribute the overpaid funds to another eligible hospital). The regulation has been modified to include this provision.

Comment: A few commenters noted that the proposed rules do not indicate the submission dates for the Annual DSH Reports. Based on 1) the data reporting that is required, 2) the fact that some of these data will need to be audited under the proposed provisions of § 455.204, and 3) the fact that the audit is proposed to be required by one year after the close of the State fiscal year to which the reporting and the audit apply, we assume the reporting is contemplated to be submitted less than a year after the close of the State fiscal year. To the extent that CMS is requesting actual (and potentially audited) cost data for the fiscal year, that information must be gathered from hospitals and reviewed by the States prior to completion of the Annual DSH Report. The commenters pointed out that much of the required data are found only on Medicare cost reports, which are submitted no sooner than five months after year-end and are desk reviewed no sooner than 11 months after year end. Given this, the reporting timeframes that appear to be contemplated are not realistic. The commenters urged that CMS allow sufficient time for the States to complete this process.

Response: We have modified the regulation to clarify that the annual DSH reports are due at the same time as the completed independent audits. We believe that this time frame is sufficient for the State, hospitals and auditors to meet their respective responsibilities to review the accuracy of the State's DSH payments.

3. Eligible Uncompensated Care

Comment: Many commenters asserted that the language in the proposed regulation that excluded bad debts from being considered part of uncompensated care exceeded the statutory authorization since the statute does not specifically address that issue. These commenters argued that bad debts are part of the burden of providing care to uninsured, and underinsured patients for whom the hospital receives no payment. The commenters believe that the proposed rule is inconsistent with Congressional intent, and actually works to weaken the statute's purpose. These commenters cited the conference report language for the Omnibus Budget Reconciliation Act of 1993 provision establishing the hospital-specific DSH limit, stating that the cost of providing services to uninsured patients would be net of any out of pocket payments received from uninsured individuals. They argued that this language clearly implies an intent that only amounts received, and not bad debt should be considered when implementing the hospital-specific DSH limit.

Response: Implicit in these comments is a misunderstanding of the term "bad debt." Bad debt arises when there is non-payment on behalf of an individual who has third party coverage. Section 1923(g)(1) is clear that the hospital-specific uncompensated care limit is calculated based only on costs arising from individuals who are Medicaid eligible or uninsured, not costs arising from individuals who have third party coverage. Thus, while the Medicaid statute does not specifically exclude bad debt from the definition of uncompensated care costs, there is nothing in the statute that would suggest that any costs related to services provided to individuals with third party coverage, including bad debt, are within that definition.

Comment: One commenter noted that if an uninsured patient does not pay the amount he or she was expected to pay, that may be recorded by the hospital as bad debt. The OBRA 1993 limit as prescribed by Section 1923(g) provides that the costs of furnished services are net of non-DSH payments under Medicaid and payments by uninsured patients. The statute does not authorize reductions to uncompensated care costs for amounts that patients were expected

to pay, only for payments that are actually made.

Response: We agree. The statutory definition of uncompensated care includes the costs of furnishing hospital services to uninsured patients, minus the payments actually received from those patients.

To the extent that hospitals do not currently separately identify uncompensated care related to services provided to individuals with no source of third party coverage from uncompensated care costs of patients with insurance, hospitals will need to modify their accounting systems to separate the two categories in order to properly document that DSH payments are within the hospital-specific limit.

Uncompensated inpatient and outpatient hospital care costs for individuals without third party coverage is then offset by payments actually made by or on behalf of those patients in the Medicaid State plan rate year under audit, except for payments made by State-only or local-only government programs for services provided to indigent patients.

Comment: Numerous commenters asserted that the proposed rule was contrary to the interpretation that bad debt should be considered when implementing the hospital-specific DSH limit that was found in CMS guidance in 1994 and again in 2002, and asked for a continuation of the prior interpretation.

Response: In 1994, CMS clarified the 1993 hospital-specific "cost" limit to include outpatient hospital services, in addition to inpatient hospital services, for Medicaid individuals and individuals with no source of third party coverage. This clarification of cost under the hospital-specific DSH limit was established in recognition of historical Congressional references to hospital services under its ongoing instruction regarding DSH. The 1994 letter to State Medicaid Directors did not specifically refer to bad debt, nor did it contain any language that should have suggested that the hospital specific limit calculation should include costs (whether compensated or uncompensated) related to individuals who had third party coverage. Similarly, the State Medicaid Director letter dated August, 2002 specifically addressed the treatment of Medicaid supplemental UPL payments for purposes of calculating uncompensated care; the treatment of costs associated with inmates of correctional facilities; and, the inclusion of Medicaid managed care days in the Medicaid inpatient utilization rate formula. Nothing in that letter addressed the issue of bad debt and the calculation of DSH eligible costs. The provisions in this rule that expressly exclude bad debt from the calculation of the hospital specific limit are based on the statutory language and do not represent any change in CMS policy.

Comment: Several commenters stated that the proposed rule fails to clarify how bad debt would be calculated.

Response: Bad debt arises when there is non-payment on behalf of an individual who has third party coverage. Section 1923(g)(1) is clear that the hospital-specific uncompensated care limit is calculated based only on costs arising from individuals who are Medicaid eligible or uninsured, not costs arising from individuals who have third party coverage. To the extent that hospitals do not currently separately identify uncompensated care related to services provided to individuals with no source of third party coverage from bad debts from patients with insurance, hospitals will need to modify their accounting systems to separate the two categories in order to properly document that DSH payments are within the hospital specific limit. We are not prescribing the details of how hospitals can accurately measure uncompensated care; the precise methodology may vary depending on individual circumstances (but will have to provide an auditable basis for the measurement). As described in later comments, the source of this information will be derived from hospital cost reports, hospital financial statements, and other hospital accounting records.

Comment: One commenter said that bad debts represent an enormous uncompensated cost to providers and pointed out that the Medicare program recognizes this reality and reimburses providers 70 percent of their Medicare bad debt write-offs. The commenter suggested that Medicaid should operate similarly to Medicare in this respect.

Response: The Medicare DSH program and the Medicaid DSH program are separate programs authorized by different Sections of the statute and with different purposes and goals. The Medicaid statute does not specifically authorize payment based on bad debts, nor does it authorize including bad debts in the calculation of the hospital specific limit under Section 1923(g)(1). We note, however, that the hospital specific limit is not a payment methodology, and States could recognize bad debts in constructing DSH payment methodologies that provide for payments less than or equal to the hospital specific limit for each hospital.

Comment: One commenter noted that the provider will report the "Provision for Medicaid Bad Debt" as a component of its uncompensated total. As such, the Provision for Bad Debt is an estimate, a Balance Sheet account, not an expense account, and deductibles and coinsurance, along with other charges, are estimated in that account. The actual bad debt expense is booked against the provision and/or allowance and most facilities would need to drill down on the Provision for Bad Debt account to get actual bad debt expense related to uninsured cost.

Response: Setting up an accounting category to aggregate charges and revenues associated with uninsured individuals receiving inpatient and/or outpatient services from a hospital should be an accounting system adjustment not far removed from the process of setting up an account for any other payer category. To the extent that hospitals do not currently separately identify uncompensated care related to services provided to individuals with no source of third party coverage from other uncompensated care costs, hospitals will need to modify their accounting systems to do so. For purposes of the initial audits under the transitional provision of the regulation, States and auditors may need to develop methodologies to analyze current audited financial statements and other accounting records to properly segregate uncompensated costs.

Only the inpatient and outpatient hospital charges associated with individuals with no source of third party coverage for such services can be applied to the Medicare cost report for purposes of calculating the uninsured uncompensated care cost component of the hospital-specific DSH limit. Hospitals must also ensure that no duplication of such charges exist in their accounting records. This information must be made available to the auditor for certification.

Comment: One commenter questioned whether claims denied by insurers for lack of prior authorization or claims submitted too late would be considered uninsured since the service is not reimbursed by the insurer and the amount is not a contractual allowance. The commenter asserted that, in that instance, the cost of that portion of the stay is uninsured.

Response: Section 1923(g)(1) refers to the costs of hospital services furnished by the hospital "in individuals who * * * have no health insurance (or other source of third party coverage)." We have always read this language to distinguish between care furnished to individuals who have health insurance

or other coverage, and care furnished to those who do not. We have never read this language to be service-specific and we believe that such an interpretation would be inconsistent with the broad statutory references to insurance or other coverage. Furthermore, such a reading would result in cost shifting from private sector coverage to the Medicaid program. We interpret the phrase "who have health insurance (or other third party coverage)" to broadly refer 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. The phrase would not include individuals with insurance that provides only excepted benefits, such as those described in 45 CFR 146.145, unless that insurance actually provides coverage for the hospital services at issue (such as when an automobile liability insurance policy pays for a hospital stay).

Improper billing by a provider does not change the status of the individual as insured or otherwise covered. In no instance should costs associated with claims denied by a health insurance carrier for such a reason be included in the calculation of hospital-specific uncompensated care costs.

Comment: One commenter argued that small hospitals budget for and count on receiving funding related to uncompensated bad debt, and argued that it would be unfair to remove bad debt from the DSH payment equation for all of 2005.

Response: Bad debt arises when there is non-payment on behalf of an individual who has third party coverage. Section 1923(g)(1) is clear that the hospital-specific uncompensated care limit is calculated based only on costs arising from individuals who are Medicaid eligible or uninsured, not costs arising from individuals who have third party coverage. As we discuss below, the regulation provides a transition period for reliance on audit findings. Findings for Medicaid State Plan years 2005–2010 will not be given weight except to the extent that the findings draw into question the reasonableness of State uncompensated care costs estimates used for calculations of prospective DSH payments for Medicaid State plan year 2011 and thereafter. This regulation requires an independent certified audit of Medicaid State plan DSH payments beginning with the Medicaid State plan rate year 2005, including comparison to the hospital-specific limits. As discussed above, this regulation does not change the costs that are included in calculating the hospital-specific limit. As discussed in a prior response, however, because the auditing process is new and will need to be refined, the 2005 audit findings will be used solely to review prospective DSH payments beginning with Medicaid State plan rate year 2011.

Comment: Several commenters stated that the recent growth of health plans and health savings accounts with high deductibles and/or have exclusion limits, is putting new burdens on hospitals in terms of unreimbursed costs. The proposed rule fails to clarify whether non-payment of beneficiaries' deductibles and co-payments would be considered bad debt and/or should be applied as a reduction in determining uncompensated care costs.

Response: Costs associated with services furnished to individuals who have limited health insurance or other third party coverage are not included in the calculation of the hospital-specific DSH limit. Specifically, the DSH limit does not include amounts associated with unpaid co-pays or deductibles for such individuals (bad-debt associated with third party coverage). Health savings accounts associated with high deductible third-party coverage typically provide a source for co-pays and deductibles as well as premium contributions or co-insurance. When health savings accounts are not sufficient to cover such charges, however, the individual remains insured and therefore hospital services costs are not considered not within the statutory calculation of the hospital specific limit.

Comment: A number of commenters stated that hospitals should not be denied DSH payments for uncollectible co-pays and deductibles for patients eligible for charity care based on a hospital's policy or for bad debts that in fact are true charity care but cannot be accounted for as such because the patient would not or could not fill out a hospital's charity care application or did not qualify for charity care but was uninsured.

Response: States have considerable flexibility in developing DSH payment methodologies, and such uncollectible amounts could be a factor in a State DSH payment methodology but can only be considered in calculating the hospital-specific limit on DSH payments if they meet the statutory criteria. Costs that can be included in the hospital-specific limit set forth at Section 1923(g) of the Act are hospital costs associated with uncompensated Medicaid costs and uncompensated costs of hospital services provided to individuals without health insurance (for example, the uninsured).

Charity care is a term used by hospitals to describe an individual hospital's program of providing free or reduced charge care to those that qualify for the particular hospital's charity care program. The term also may be defined by a State in determining qualification for DSH payments under the low-income utilization rate methodology set forth in Section 1923(b)(3) of the Act. Depending on the definition used, hospital costs associated with the uninsured may be a subset of charity care in the hospital or may entirely encompass a hospital's charity care program. Regardless of a hospital's definition/parameter on what constitutes charity care, States and hospitals must comply with Federal Medicaid DSH law and policy guidance in determining what portion of their specific charity care program costs qualify under the hospital-specific DSH cost limits.

To the extent that hospitals do not separately identify uncompensated care related to services provided to individuals with no source of third party coverage, hospitals will need to modify their accounting systems to do so. And hospitals must ensure that no duplication of such charges exist in their accounting records. For purposes of the initial audits, States and auditors may need to develop methods to analyze current audited financial statements and other accounting records to properly segregate uncompensated costs.

Comment: A few commenters noted that if a patient does not have health insurance, the costs of services provided to that patient may be included in calculating the hospital-specific limit, even if revenues related to that patient are uncollectible and eventually written off as bad debt. They argued that the touchstone for purposes of the DSH limit is whether the individual has third party coverage, not whether the hospital has or has not treated the patient's account as bad debt.

Response: We agree. As long as the costs are for services furnished to uninsured patients, they may be included in the calculation of the hospital-specific limit, regardless of whether the hospital treats the costs as bad debt on its own books.

Comment: A few commenters said that hospitals are currently required to report both charity and bad debt costs to the State Medicaid program to assure that the hospital will not receive excess Medicaid DSH payment. The commenters indicated that this requirement is part of an approved

Medicaid State plan that has been in place for numerous years, and asserted that the proposed requirements would be an unwarranted departure from this practice.

Response: We recognize that this rule may necessitate some changes in current practices, but we believe these changes are warranted in order to ensure compliance with the statutory hospital-specific limit. As discussed above, the statutory calculation does not refer to charity care or bad debts, but expressly refers to uncompensated costs of furnishing hospital services to individuals eligible for Medicaid or individuals who have no health insurance or other third party coverage.

Comment: A few commenters were concerned that the regulation lacks a clear and appropriate definition of "third-party coverage." In particular, the commenters believe that third-party coverage should explicitly be defined in a manner that makes clear that third-party coverage does not include State and local programs to pay for care for indigent and uninsured individuals and that "lack of third-party coverage" also encompasses patients who lack coverage for the service provided, not necessarily any coverage at all.

Response: We disagree. As discussed above, Section 1923(g)(1) of the Act refers to costs of hospital services furnished to "individuals without health insurance (or other source of third party coverage)." We have always read this language to distinguish between care furnished to individuals who have health insurance or other coverage, and care furnished to those who do not. We have never read this language to be service-specific and we believe that such an interpretation would be inconsistent with the broad statutory references to insurance or other coverage. Furthermore, such a reading would result in cost shifting from private sector coverage to the Medicaid program. We interpret the phrase "who have health insurance (or other third party coverage)" to refer 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.

4. Dual Eligibles

Comment: A few commenters indicated that days attributable to dual eligibles should be included in the calculation described in Section 1923(a) relating to determining DSH eligibility.

Response: The Medicaid Inpatient Utilization Rate (MIUR) is a calculation that includes all Medicaid eligible days. To the extent that an inpatient hospital day for a dually-eligible Medicare/Medicaid patient qualifies as a Medicaid day, that day would be included in the MIUR calculation.

Comment: One commenter questioned whether the costs attributable to dual eligibles be included in the calculation described in SSA § 1923(g) relating to uncompensated care costs. The commenter asserted that these costs should be excluded because the purpose of the DSH upper payment limit is to limit DSH payments to hospitals to no more than the difference between the cost and payments of Medicaid and the uninsured. The commenter indicated that, since Medicare is the primary payer for the duals, it seems appropriate to exclude the costs of those patients from this calculation, since the payments are also excluded.

Response: We disagree; since Section 1923(g)(1) does not contain an exclusion for dually eligible individuals, we believe the costs attributable to dual eligibles should be included in the calculation of the uncompensated costs of serving Medicaid eligible individuals. But in calculating those uncompensated care costs, it is necessary to take into account both the Medicare and Medicaid payments made, since those payments are contemplated under Title XIX. In calculating the Medicare payment for service, the hospital would have to include the Medicare DSH adjustment and any other Medicare payment adjustment (Medicare IME and GME) with respect to that service.

5. Charity and Indigent Care

Comment: One commenter questioned how a hospital would classify individuals who had Medicaid coverage for some discharges and no insurance for others.

Response: The hospital-specific DSH limit comprises uncompensated care costs of furnishing inpatient and outpatient hospital services to Medicaid eligible individuals and individuals with no source of third party coverage for the inpatient and outpatient hospital services they receive. If an individual is Medicaid eligible on the day they received inpatient or outpatient hospital services, then those services would be included in calculating the hospital-specific limit. To the extent the Medicaid payment does not fully cover the cost of the inpatient or outpatient hospital services provided, the unreimbursed costs of those services would be counted in calculating that limit. Services that are not within the State's definition of inpatient or outpatient hospital services, and any revenue associated with such services, however, would not be included in that calculation. The same is true for hospital services furnished to individuals whose insurance status fluctuates; hospital services furnished while individuals are uninsured would be included in the calculation, and those furnished while individuals are insured would not be included.

Comment: One commenter requested an explanation of the difference between "charity care" and care provided to the uninsured.

Response: As we explained above, charity care is a term used by hospitals to describe an individual hospital's program of providing free or reduced charge care to those that qualify for the particular hospital's charity care program. The term also may be defined by a State in determining qualification for DSH payments under the low-income utilization rate (LIUR) methodology set forth in Section 1923(b)(3) of the Act. Depending on the parameters of the individual charity care programs, hospital costs associated with the uninsured may be a subset of charity care in the hospital or may entirely encompass a hospital's charity care program. Regardless of a hospital's definition/parameter on what constitutes charity care, States and hospitals must comply with Federal Medicaid DSH law and policy guidance in determining what portion of their specific charity care program costs qualify under the hospital-specific DSH cost limits.

As noted, charity care is addressed in the Medicaid statute at Section 1923(b)(3)(B)(i) of the Act and is a variable in the formula used to determine a hospitals low-income utilization rate as part of the qualification criteria for DSH payments. The charity care variable, while not further defined by statute is offset in the LIUR formula by the subsidies provided by state and local governments to assist hospitals in serving individuals with no other source of third party coverage. For purposes of defining a hospital's LIUR, States may adopt a reasonable definition of charity care to reflect care given free or with reduced charge to indigent individuals.

The term is not used in Section 1923(g) of the Act which defines the costs eligible for DSH payments and that limits DSH eligible costs to the uncompensated inpatient and outpatient hospital costs associated with Medicaid eligible individuals and individuals without health insurance, (for example, the uninsured).

For purposes of Section 1923(g)(1) hospital-specific DSH limits, uninsured individuals are those individuals without a source of third-party coverage

(except coverage from State or local programs based on indigency). Self-pay, in terms of the hospital-specific DSH limits, are those individuals who are responsible to pay for the hospital services provided them because they have no source of third party coverage, (for example, the uninsured). Revenues required to be offset against a hospital's DSH limit would include any amounts received by the hospital by or on behalf of either "self-pay" or uninsured individuals during the Medicaid State plan rate year under audit (except payments from State or local programs based on indigency).

To the extent that hospitals do not separately identify uncompensated care related to services provided to individuals with no source of third party coverage from other uncompensated care costs, hospitals will need to modify their accounting systems to do so. For purposes of the initial audits, States and auditors may need to develop methodologies to analyze current audited financial statements and other accounting records to properly segregate uncompensated costs. It is important to note that only the inpatient and outpatient hospital charges associated with individuals with no source of third party coverage for such services can be applied to the Medicare cost report for purposes of calculating the uninsured uncompensated care cost component of the hospital-specific DSH limit. Hospitals must also ensure that no duplication of such charges exist in their accounting records. This information must be made available to the auditor for certification.

To the extent that hospitals include such eligible uncompensated inpatient and outpatient hospital care as part of their hospital-specific DSH limit calculation, the included costs must be offset by payments actually made by or on behalf of patients with no source of third party coverage in the Medicaid State plan rate year under audit. These payments do not include payments made by State-only or local-only government programs for services provided to indigent patients.

Comment: A few commenters requested a definition of Indigent Care Revenue. They believe the language suggests that this term refers to revenue from individuals with no source of third party coverage for inpatient and outpatient hospital services they receive, irrespective of the individuals' income, despite the fact that "indigent" usually implies low income. The commenters would like CMS to confirm that this interpretation is correct.

Response: We agree that this term was confusing and we have changed its usage in the final regulation. We refer instead to "uninsured" revenue to refer to compensation for hospital services received from or on behalf of individuals with no source of third party coverage (regardless of whether the patient is indigent). These payments do not include payments made by State-only or local-only government programs for services provided to indigent patients.

Comment: Some commenters asked for more clarity with regard to what is included in the category of indigent care revenue (§ 447.299(c)(12)), and a definition of third party payments. They asked in particular about the treatment of payments made by State and other government programs make payments to hospitals on behalf of indigent individuals. The regulation should contain language that clarifies this in order to avoid confusion.

Response: We agree. Section 1923(g)(1)(A) of the Act specifies that, "payments made to a hospital for services provided to indigent patients by a State or a unit of local government within a State, shall not be considered to be a source of third party payment." Therefore, we have changed the usage of the term "indigent care revenue" and refer instead to "uninsured revenue." In addition, we have added language to clarify that uninsured revenue does not include payments for hospital services provided to indigent patients by a State or a unit of local government within a State.

Comment: One commenter questioned how CMS previously audited indigent care revenue.

Response: CMS has previously performed certain reviews of State DSH programs as part of its financial management work plan under Medicaid. In addition, the Office of the Inspector General has previously performed several reviews of State DSH programs nationally.

Comment: One commenter stated CMS should clarify whether the required data element refers to services provided to patients whose third party coverage makes no payment to the hospital; for example, the patient may have exhausted benefits coverage, the hospital may have failed to properly bill for the service, or the service provided may not be a covered benefit.

Response: Costs included in calculating the hospital-specific limit do not include costs associated with individuals who are not Medicaid-eligible and have health insurance, even if that health insurance is limited. In no instance should costs associated claims denied by a health insurance carrier due to improper billing be included in the hospital-specific DSH limit. In addition, to the extent that the inpatient and/or outpatient hospital services received are not within the definition of inpatient and/or outpatient hospital services under the State Medicaid plan, such service costs should not be included in calculating the hospital-specific DSH limit. The treatment of inpatient and outpatient hospital services provided to the uninsured and underinsured also must be consistent with the definition of inpatient and/or outpatient services under the approved Medicaid State plan.

Comment: One commenter questioned at what point an individual is coded as self pay.

Response: The hospital-specific limit is calculated, in part, using uncompensated costs of providing inpatient and outpatient hospital services to individuals without health insurance (for example, the uninsured). While some hospitals may refer to such individuals as "self-pay," that term could have a broader meaning.

For purposes of determining hospital-specific DSH limits, uninsured individuals are those individuals without health insurance or another source of third-party coverage for inpatient and/or outpatient hospital services. Information on insurance or third party coverage status is routinely collected by hospitals, and should be found in patient records. We interpret the phrase "who have health insurance (or other third party coverage)" to broadly refer 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. The phrase would not include individuals who have insurance that provides only excepted benefits, such as those described in 42 CFR 146.145, unless that insurance actually provides coverage for the hospital services at issue (such as when an automobile liability insurance policy pays for a hospital stay).

Revenues required to be offset against a hospital's DSH limit would include any amounts received by the hospital by or on behalf of uninsured individuals during the Medicaid State plan rate year under audit.

Comment: One commenter noted that the phrasing of this requirement implies that the State should report all payments unrelated to third party coverage. The commenter suggested that, as some individuals can pay for certain hospital bills privately, these payments would be included within

this definition and those private pay amounts would be included as Indigent Care Revenue. The commenter asserted that, if this is correct, bad debts should be included in uncompensated care; and if this is incorrect, CMS should clarify what amounts are to be included as revenue from the indigent, and how the indigent and their revenues are to be identified.

Response: It would be incorrect to include reductions in uncompensated care in calculating the hospital-specific limit based on private pay amounts for individuals with insurance or other third party coverage. Revenues required to be offset against a hospital's DSH limit would include any amounts received by the hospital by or on behalf of uninsured individuals during the Medicaid State plan rate year under audit. Section 1923(g)(1)(A) of the Act requires that the hospital-specific cost limit be reduced by payments under Title XIX and payments made by uninsured patients. To the extent that hospitals do not separately identify uncompensated care related to services provided to individuals with no source of third party coverage from uncompensated care costs not eligible under the hospital-specific DSH limits, hospitals will need to modify their accounting systems to do so. For purposes of the initial audits, States and auditors may need to develop methodologies to analyze current audited financial statements and other accounting records to properly segregate uncompensated costs.

In sum, to the extent that hospitals include such uncompensated inpatient and outpatient hospital care as part of their hospital-specific DSH limit calculation, the included costs must be offset only by payments actually made by or on behalf of patients with no source of third party coverage in the Medicaid State plan rate year under audit. These payments do not include payments made by State-only or local-only government programs for services provided to indigent patients, nor do they include payments by patients with a source of third party coverage. We have revised the regulation text to try to clarify these points.

Comment: One commenter believes CMS' use of the term "uncompensated care costs" throughout the regulation and preamble may be confusing because the hospital industry generally uses the same term to mean the combined costs related to charity care and bad debt for all patients (not limited to uninsured patients). The commenter suggested that CMS intends a more limited use of the term in this regulation that would be restricted to uncompensated care costs associated with Medicaid and uninsured patients. The commenter suggested that CMS should not use the term "uncompensated care costs" to refer to uncompensated costs associated only with Medicaid and uninsured patients. To better facilitate hospital compliance, the commenter recommends that CMS use a different term, such as "uncompensated Medicaid and uninsured costs."

Response: While we regret any confusion, the term "uncompensated care costs" has been used in this concept since the statutory change in 1993, and we have sought to alleviate confusion by explaining in detail the meaning of the term in this context. The uncompensated care costs eligible under DSH were clearly articulated in the August 26, 2005 proposed regulation. That is, the uncompensated care costs eligible under the hospital-specific DSH limit include the unreimbursed costs of providing inpatient and outpatient hospital services to Medicaid eligible individuals and the unreimbursed costs of providing inpatient and outpatient hospital services to individuals with no source of third party reimbursement. Therefore, all uncompensated costs billed as inpatient hospital services and outpatient hospital services to Medicaid eligible individuals and to individuals with no source of third party reimbursement are eligible under the DSH limit.

To the extent that hospitals do not separately identify uncompensated care related to services provided to individuals with no source of third party coverage from uncompensated care costs not eligible under the hospital-specific DSH limits, hospitals will need to modify their accounting systems prospectively to do so. For purposes of the initial audits, States and auditors may need to develop methodologies to analyze current audited financial statements and other accounting records to properly segregate uncompensated costs.

Comment: A few commenters requested a definition of what is considered uninsured.

Response: We interpret the statutory phrase "who have health insurance (or other third party coverage)" to broadly refer 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. The phrase would not include individuals who insurance that provides only excepted benefits, such as those described in 42 CFR 146.145, unless that insurance actually provides coverage for the hospital services at issue (such as when an automobile liability insurance policy pays for a hospital stay).

Comment: One commenter stated that there could be a case where a patient comes into a hospital and has an income over the charity care level (for example, 400 percent over the poverty level) and the patient charges are not booked to uncompensated care but booked to self-pay. The patient does not pay and the account is written off to bad debt. In that case, the commenter asked whether the cost of that charge would be counted as Medicaid DSH or as a component of bad debt. In addition, the commenter asked if the facility could write-off the account as uncompensated care and not bad debt. Currently, many facilities may be writing off to bad debt because the regulations appear to be more specific.

Response: This regulation does not directly address all potential DSH payment methodologies, but does address the calculation of the hospital-specific limit on DSH payments. As discussed in previous responses, the categories of charity care and self pay are not relevant to calculation of the hospital-specific limit. For the calculation, it is necessary to know the uncompensated costs of providing inpatient and outpatient hospital services to individuals without health insurance (for example, the uninsured). To the extent that hospitals do not separately identify uncompensated care related to services provided to individuals with no health insurance or other source of third party coverage, hospitals will need to modify their accounting systems to do so.

Comment: One commenter questioned whether it is CMS' intent that the uninsured, their charges, their payments, and their costs be calculated and reported without regard to any income or asset threshold? Please explain CMS' intent regarding asset and income thresholds and the uninsured.

Response: The statutory provision at Section 1923(g)(1) does not provide for any income or asset threshold in measuring uncompensated care for uninsured individuals for purposes of the hospital-specific limit on DSH payments. Presumably, such individuals with higher incomes will be able to pay some or all of the cost of their care, and the costs will thus not be uncompensated. Moreover, we reiterate that the hospital-specific limit is not a DSH payment methodology, and States may impose stricter limits on costs that they will consider in determining payment.

Comment: One commenter noted that the CMS proposed rule would reward hospitals whose liberal charity policies

result in high charity care amounts. By not using their best efforts to collect on patient's accounts, the commenter indicated that these institutions pass on a greater financial burden to the Medicaid program under this proposal. The commenter asserted that hospitals have a duty to make a reasonable effort when collecting accounts from patients who do not have insurance or in instances where insurance does not provide complete coverage.

Response: This rule implements the audit and reporting of DSH payments to determine compliance with the hospital-specific DSH limits and is not intended to create an incentive for qualifying DSH hospitals not to collect on patients' accounts. First, States are limited in their ability to make DSH payments by their annual DSH allotments. Second, States are not required to make DSH payments to qualifying hospitals in an amount equal to the hospital-specific limit. The hospital-specific limit is not a DSH payment methodology, and States may impose stricter limits on costs that they will consider in determining payment. Taken together, we believe it is unlikely hospitals will forgo revenues from patients in hope that such costs/services would be fully subsidized by the Medicaid DSH payment.

Comment: One commenter said that several States have many non-Medicaid indigent care programs. In many of these programs, the commenter indicated that the sponsoring government or agency provides a minimal payment to the hospital. The commenter noted that the proposed regulations are not clear whether the loss on such programs/patients is includable in uncompensated care costs.

Response: Inpatient and outpatient hospital service costs provided to beneficiaries of State-only indigent care programs that have no other source of third party coverage may be included in a hospital's DSH cost limit. Section 1923(g)(1)(A) of the Act specifies that, "payments made to a hospital for services provided to indigent patients by a State or a unit of local government within a State, shall not be considered to be a source of third party payment." Such State or local government payments should not be offset against the inpatient and outpatient hospital service costs associated with individuals qualifying for such State or local government payment programs.

However, it is important to note that Medicaid inpatient and outpatient hospital revenues received by hospitals in excess of Medicaid inpatient and outpatient hospital costs must also be offset against the eligible uncompensated inpatient and outpatient hospital costs associated with individuals with no source of third party coverage for the inpatient outpatient hospital services they received.

Comment: One commenter requests CMS clarify how the indigent are to be identified. In particular, the commenter asked for clarification on the treatment of other State or local funded services for indigent patients and how that fits into the reporting for the uninsured, and noted that some hospitals have included items in the "uninsured" category that are State or locally funded. Examples include items such as county jail patients, public employee workers' compensation funded services, and services to juveniles referred from secure State facilities.

Response: We interpret the phrase "who have health insurance (or other third party coverage)" to broadly refer 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. The phrase would not include individuals who insurance that provides only excepted benefits, such as those described in 42 CFR 146.145, unless that insurance actually provides coverage for the hospital services at issue (such as when an automobile liability insurance policy pays for a hospital stay). The phrase also does not include coverage or payments made on the basis of indigency by a State or a local unit of government within the State, pursuant to Section 1923(g)(1)(A) of the Act.

Inpatient and outpatient hospital costs incurred for individuals for which the State or local government is responsible on a basis other than indigency should not be included in calculating the hospital-specific limit. This would include costs for care for which the State makes payments on the basis of status as State employees, prisoners or other wards of the State. A State Medicaid Director letter dated August 16, 2002 specifically addressed the issue of treatment for Medicaid DSH purposes of hospital costs associated with inmates of correctional facilities. The letter specified that these costs were ineligible as uncompensated costs for purposes of DSH because the inmates are wards of the State and the State is directly responsible for their basic economic and medical needs. Failure to do so would be in violation of the eighth Amendment of the Constitution. Similarly, inmates of a county jail or juvenile facility are wards of the State or local government detaining them and their basic economic and medical needs are the obligation of that governmental entity.

In addition, uncompensated inpatient and/or outpatient hospital costs associated with providing services for public employee worker's compensation programs are not eligible for inclusion in a hospital's DSH limit. Worker's compensation programs provide third party coverage for medical services that is not based on indigency.

Comment: One commenter said that CMS should further clarify what costs may be included in the costs of services for the uninsured, in particular, how ancillary and pharmacy services should be addressed.

Response: There are no special accounting principles related to the reporting and auditing requirements under this regulation. Costs and revenues should be determined based on otherwise applicable cost accounting principles for hospitals. As part of the Medicare 2552–96 cost reporting and allocation step down process, ancillary service costs may be allocated to inpatient and outpatient hospital services provided to Medicaid eligible patients and patients with no source of third party coverage. To the extent that the allocated ancillary service costs are not reimbursed they may be included in the hospital-specific DSH limit.

Pharmacy service costs are separately identified on the Medicare 2552–96 cost report and are not recognized as an inpatient or outpatient hospital service. Pharmacy service costs that are not part of an inpatient or outpatient rate and are billed as pharmacy service and reimbursed as such are not considered eligible for inclusion in the hospital-specific uncompensated cost limit.

Comment: Many commenters stated that the current accounting systems at most hospitals would not allow them to accurately segregate payments received from individuals with third party coverage from payments received from individuals without third party coverage.

Response: To the extent that hospitals do not separately identify uncompensated care related to services provided to individuals with no source of third party coverage from uncompensated care costs not eligible under the hospital-specific DSH limits, hospitals will need to modify their accounting systems to prospectively do so. Setting up an accounting category to aggregate charges and revenues associated with uninsured individuals receiving inpatient and/or outpatient services from a hospital should be an accounting system adjustment not far removed from the process of setting up

an account for any other payer category. For purposes of the initial audits, States and auditors may need to develop methodologies to analyze audited financial statements and other accounting records to properly segregate uncompensated costs.

Comment: A few commenters stated that, in their States, for the vast majority of DSH hospitals, the State achieves compliance with the hospital-specific DSH limit because DSH payments are less than Medicaid uncompensated care alone, which is calculated for each hospital on the Medicaid cost reporting forms. For this reason, the commenters asserted that the State does not require most DSH hospitals to report costs of uninsured patients on the cost reporting forms, and requiring them to do so would be an unnecessary and significant burden. The commenters recommended that the proposed rule be amended to include a provision granting States the option to not report uninsured costs for some or all hospitals where Medicaid losses justify the DSH payment made. Some commenters recommend that the proposed rule be amended to include a provision granting States the option to not report uninsured costs for some or all hospitals where Medicaid losses alone justify the DSH payment.

Response: The statute requires that each State report to CMS data, and submit a certified audit, that verifies that all hospitals receiving DSH payments under the Medicaid State plan actually qualify to receive such payments and that such payments do not exceed the hospital-specific DSH limit. Even if a State only makes DSH payments under its approved Medicaid State plan that relate to the uncompensated care of providing inpatient and outpatient hospital services to Medicaid individuals (that is, Medicaid shortfall), it would be possible for payments to a hospital to exceed the hospital-specific limit if the hospital had a surplus in furnishing hospital services to the uninsured. While this may be an unlikely circumstance, we cannot at this time be certain that it never occurs. Therefore, in such a circumstance we will accept reporting limited to Medicaid uncompensated care only when the hospital provides a certification that it incurred additional uncompensated care costs serving uninsured individuals. When we review certified audit reports submitted by States, we will consider whether more flexibility would be warranted, and we may address the issue in future reporting instructions.

Comment: Numerous commenters cited the agency's 1994 letter to State Medicaid programs as offering additional guidance by stating that the cost of services provided individuals with third party coverage, but whose third party coverage did not cover the hospital services the individual received, could be included. These commenters asked for CMS to incorporate this principle into this final rule.

Response: We do not agree with this reading of the 1994 CMS State Medicaid Director letter, which did not refer to underinsured individuals. Moreover, the statute appears to be clear on this issue. While we regret any misconceptions about that letter, we take this opportunity to clarify that the only costs relevant to the calculation of the hospital-specific limit are costs of furnishing hospital services to individuals who are Medicaid eligible or who have no health insurance (or other source of third party coverage).

Comment: One commenter questioned whether claims denied by insurers for lack of medical necessity are considered uninsured.

Response: The costs of services for individuals who have health insurance are not included in calculating the hospital-specific limit, even if insurance claims for that particular service are denied for any reason. Section 1923(g)(1) of the Act includes in the calculation costs of providing hospital services to individuals without health insurance or other third party coverage (for example, the uninsured). Claims denied by a health insurance carrier, including a Medicaid contracted managed care organization, for any reason other than the inpatient/outpatient service or services provided were not covered services within the individuals health benefit package are furnished to individuals who have health insurance coverage. The same is true of services for which claims are denied due to improper billing, lack of preauthorization, lack of medical necessity, or non-coverage under the third party insurance package.

Comment: One commenter stated that if an individual has an ambulatory benefit, but does not have an inpatient benefit, this individual should be considered uninsured when inpatient hospital treatment is provided. The costs a hospital incurs for the provision of care to these individuals should be included in determining the cost of uncompensated care.

Response: We interpret the phrase "who have health insurance (or other third party coverage)" to broadly refer 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. The phrase would not include individuals who have insurance that provides only excepted benefits, such as those described in 42 CFR 146.145, unless that insurance actually provides coverage for the hospital services at issue (such as when an automobile liability insurance policy pays for a hospital stay). An individual with insurance that provides only an ambulatory benefit would qualify as having health insurance unless the benefit is further limited so that it is considered an excepted benefit (for example, restricted to onsite ambulatory medical clinics, limited to a particular diagnosis, or restricted to an indemnity benefit). We are not aware of health insurance plans that offer only ambulatory benefits, and do not believe this is a common practice in the industry.

6. Section 1011 Payments

Comment: Numerous commenters requested an explanation of the rationale for requiring States to consider Section 1011 payments in DSH limit calculations when the statute does not refer to Section 1011 payments as a factor in determining the hospital's uncompensated care burden. They asserted that Section 1011 payments do not appear to fit in the statutory categories of Medicaid payments, health plan payments, or payments made by uninsured patients, that are required to be "netted" from cost for the purpose of the DSH limit calculations. The commenters request CMS to amend the proposed rule to eliminate the proposed treatment of Section 1011 payments.

Response: Section 1011 payments are made to a hospital for the costs incurred for the provision of specific services to specific aliens to the extent that the provider was not otherwise reimbursed (through insurance or otherwise) for such services. Because a portion of the Section 1011 payments are made for uncompensated care costs that are also eligible under the hospital-specific DSH limit (for example, costs associated with those Section 1011 eligible aliens with no source of third party coverage for the inpatient and outpatient hospital services they receive and inpatient and outpatient hospital services not considered eligible under Section 1011), a defined portion of the Section 1011 payment must be recognized as an amount paid on behalf of those "uninsured" Section 1011 eligible aliens, which would offset the hospital's uncompensated cost under the hospital-specific limit. The information necessary to properly segregate eligible

1011 costs under the hospital-specific DSH limit from Section 1011 costs not eligible under the hospital-specific limit is already maintained in hospital accounting records for purposes of compliance with Section 1011. Section 1011 costs not eligible under the hospital-specific DSH limit include any inpatient and/or outpatient service provided to a Section 1011 eligible individual who also had a source of third party coverage for such services (for example, commercial insurance, workmen's compensation, automobile insurance coverage). Similarly, Section 1011 revenues attributable to inpatient and outpatient hospital services provided to Section 1011 eligible aliens with a source of third party coverage for the inpatient and outpatient hospital services they receive or that are inpatient and outpatient hospital services not considered eligible under Section 1011 would not be offset against eligible uncompensated care costs under the hospital-specific limit.

Considering the portion of Section 1011 payments attributable to eligible aliens with no source of third party coverage for the inpatient and outpatient hospital services they receive as revenue for purposes of calculating the hospital-specific DSH limit does not change the hospital's ability to be fully reimbursed for eligible uncompensated inpatient and outpatient hospital services. This portion of the Section 1011 payments are an additional source of funding to hospitals and can assist States in managing the DSH allotments in a manner that recognizes a broader universe of hospitals that provide a disproportionate share of services to Medicaid and low-income individuals. Offsetting the portion of the Section 1011 payments in no way prevents a hospital from receiving DSH payments up to 100 percent of the unreimbursed cost of providing inpatient and outpatient hospital services to individuals with no source of third party coverage. Section 1011 revenues attributable to inpatient and outpatient hospital services provided to Section 1011 eligible aliens with a source of third party coverage for the inpatient and outpatient hospital services they receive or that are inpatient and outpatient hospital services not considered eligible under Section 1011 would not be offset against eligible uncompensated care costs under the hospital-specific limit.

The form associated with the reporting requirements has been modified to separately identify Section 1011 payments from other revenue sources.

Comment: A few commenters noted the State does not have access to information on Section 1011 payments made to hospitals by the Secretary. The commenters asked whether CMS intends to provide each State a hospital-specific report that quantifies the Section 1011 payments and the time period during which the payments were made. If not, the commenters asked for clarification on how States should collect and validate this information.

Response: CMS has produced a General DSH Audit and Reporting Protocol, which specifically addresses the source documents to be utilized in performing the DSH audit and report. One of the source documents will be hospital audited financial statements. The Section 1011 payments would necessarily be identified as a revenue source in the hospitals' audited financial statements. Each DSH hospital must identify to the State the portion of Section 1011 payments received during the Medicaid State plan rate year under audit as described in the prior response to comment. These payments will then be considered a revenue offset against the total eligible uncompensated care comprising the hospital-specific DSH limit. The information necessary to properly segregate eligible Section 1011 costs under the hospital-specific DSH limit from Section 1011 costs not eligible under the hospital-specific limit is already maintained in hospital accounting records for purposes of compliance with Section 1011. Section 1011 costs not eligible under the hospital-specific DSH limit include any inpatient and/or outpatient service provided to a Section 1011 eligible individual who also had a source of third party coverage for such services (for example, commercial insurance, workmen's compensation, automobile insurance coverage). Similarly, Section 1011 revenues attributable to inpatient and outpatient hospital services provided to Section 1011 eligible aliens with a source of third party coverage for the inpatient and outpatient hospital services they receive or that are inpatient and outpatient hospital services not considered eligible under Section 1011 would not be offset against eligible uncompensated care costs under the hospital-specific limit.

Comment: One commenter requests clarification as to how CMS proposes that such information be considered. If a State is required to rely on self-reported hospital data then the State also requests clarification regarding why self-reported hospital data is sufficient for one purpose (Section 1011 payments or managed care payments) but not another (regular rate payments).

Response: We anticipate that States and auditors will use the best available data. The DSH audit will rely on existing financial and cost reporting tools currently used by all hospitals participating in the Medicare program, and available State data on Medicaid fee-for-service payments. These documents would include the Medicare 2552–96 cost report and audited hospital financial statements and accounting records in combination with information provided by the States' Medicaid Management Information Systems (MMIS) and the approved Medicaid State plan governing the Medicaid payments made during the audit period. There are three specific types of revenues that must be included in the audit to which the State conducting the audit will not have access. They are: (1) Medicaid and DSH payments received from States other than the State in which the hospital is located, (2) Medicaid MCO payments and, (3) payments by or on behalf of uninsured individuals (other than State and local government indigent care payments). The State and CMS must rely on hospital audited financial statements and accounting records to provide this information. In addition, hospital cost information is available only from a reporting hospital. The State and CMS must rely on hospital 2552–96 cost reports to provide this information. When the State has the most central and current information through its MMIS (for example, data on Medicaid payments in State fee-for-service inpatient hospital, outpatient hospital and DSH payments) that system will be the best source of the information.

Comment: One commenter suggested that CMS should offset Medicare DSH payments with these payments.

Response: There is no statutory authority to support the commenter's suggestion. The hospital-specific DSH limit does not contemplate consideration of costs and revenues for services provided to Medicare beneficiaries except when those beneficiaries are dually eligible for Medicaid services. Moreover, Medicare DSH payments are governed under separate statutory authority and recognize the higher costs incurred by DSH facilities that are associated with Medicare hospital services, and do not recognize costs related to services provided to uninsured individuals.

In contrast, Section 1011 payments specifically reimburse hospital costs of providing uncompensated emergency services they are required to provide under Section 1867 of the Act (EMTALA) to undocumented and other eligible aliens, some of whom have no

source of third party coverage for the inpatient and outpatient hospital services they receive. To the extent a portion of Section 1011 payments are paid to a hospital to offset these uncompensated care costs eligible under the hospital-specific DSH limit, a defined portion of the Section 1011 payment must be recognized as a payment on behalf of those individuals when determining a hospital's eligible uncompensated cost under the hospital-specific DSH limit. If the hospital also received a Section 1011 payment to satisfy the same uncompensated costs that are included as part of the hospital's specific DSH limit, the Section 1011 payment must be included as an offsetting revenue source reducing the total amount of uncompensated care eligible for Medicaid DSH payments.

Comment: One commenter said that the requirement to consider Section 1011 payments as revenue offsetting costs of services for the uninsured could significantly reduce DSH payments for vulnerable DSH-eligible hospitals and children's hospitals.

Response: CMS does not believe that treating the portion of Section 1011 payments, for those uninsured Section 1011 eligible aliens, as revenue for purposes of calculating the hospital-specific DSH limit in any way compromises the hospital's ability to be fully reimbursed for uncompensated inpatient and outpatient hospital services. Instead, Section 1011 payments are an additional source of funding to hospitals and can assist States in managing the DSH allotments in a manner that recognizes a broader universe of hospitals that provide a disproportionate share of services to Medicaid and low-income individuals. Offsetting the portion of Section 1011 payments in no way prevents a hospital from receiving DSH payments up to 100 percent of the unreimbursed cost of providing inpatient and outpatient hospital services to individuals with no source of third party coverage. Section 1011 revenues attributable to inpatient and outpatient hospital services provided to Section 1011 eligible aliens with a source of third party coverage for the inpatient and outpatient hospital services they receive or that are inpatient and outpatient services not considered eligible under Section 1011 would not be offset against eligible uncompensated care costs under the hospital-specific limit.

Comment: One commenter complained that this regulation places a reporting and verification requirement on the State and on hospitals in the State for the Federally administered Section 1011 program.

Response: The reporting obligation is based on the requirements under the Medicaid program, which is administered by States. To the extent that Section 1011 payments are paid to a hospital to offset uncompensated care costs eligible under the hospital-specific DSH limit, this Section 1011 payment must be recognized as a payment on behalf of Section 1011 eligible individuals when determining a hospital's eligible uncompensated cost under the hospital-specific DSH limit. The Section 1011 payments are Federal payments that directly pay hospitals and certain other providers for their otherwise unreimbursed costs of providing services required by Section 1867 of the Act (EMTALA). The hospital-specific limit is calculated taking into consideration payments made by or on behalf of uninsured individuals, and there is no statutory exception for payments made under Section 1011.

Comment: One commenter asserted that it would be harmful to States to identify which hospitals received Section 1011 payments and the amount of Section 1011 payments received prior to allocating DSH funds.

Response: It is not clear what harm would result from greater understanding of the revenues available to pay for uncompensated care. Moreover, reporting is consistent with the need to verify the appropriateness of DSH payments, for the reasons discussed above. And, as we discussed above, proper accounting for Section 1011 payments may provide States with additional flexibility in the use of their limited DSH allotment.

Comment: One commenter requests CMS to clarify for providers and states that only supplemental Medicaid payments (to the exclusion of Section 1011 funds, which are not Medicaid program payments) be included for purposes of counting which payments are deemed to have been paid to a hospital as part of the hospital-specific DSH limit. The commenter requested that CMS explicitly exclude the Section 1011 funds from the "Verification 4" requirement.

Response: We disagree with the commenter and instead are clarifying that all Medicaid payments must be considered in the calculation of revenues offsetting costs, as well as a portion of Section 1011 payments. Verification four specifically directs the auditor to ensure that, "States included all payments under this title, including supplemental payments, in the calculation of hospital-specific DSH payment limits." This verification addresses the treatment of Medicaid payments and in particular, payments that are in excess of Medicaid cost. To alleviate any confusion, we separately address Section 1011 payments, which are made by the Federal government on behalf of undocumented and other specified aliens receiving emergency services required under Section 1867 of the Act. These payments do not meet the State or local government exclusion and must be treated as a payments received on behalf of uninsured individuals for purposes of determining a hospitals'-specific DSH limit.

The form associated with the reporting requirements has been modified to separately identify Section 1011 payments from other revenue sources.

7. Unduplicated Medicaid and Uninsured Counts

Comment: Numerous commenters stated it is feasible for States to report the unduplicated number of Medicaid eligible individuals, but not to report unduplicated uninsured patients. These commenters asserted that such information appears to serve no purpose relative to the requirements this rule is intended to enforce. The commenters believe this requirement to be unreasonable, unwarranted, and/or unnecessary, with no clear relationship between this data and DSH program and this reporting requirement should be eliminated.

Response: The regulation has been modified to remove the requirement to report unduplicated counts of both Medicaid and uninsured patients. The form associated with the reporting requirements has been modified to remove the Section addressing unduplicated Medicaid counts and unduplicated uninsured counts.

8. MIUR and LIUR Calculations

Comment: Many commenters asserted that the proposed rule would inappropriately limit the charity care component of the Low Income Utilization Rate (LIUR) DSH qualification measurement under Section 1923(b)(3) of the Act to only charity care rendered to the uninsured, who do not have third-party coverage for hospital services, thereby excluding charity care for the underinsured. They argued that the statute does not limit this ratio to services provided uninsured individuals. They pointed out that, while the lack of third-party coverage is an important factor in any hospital's charity care policy, it is not the only factor. They asserted that charity care is often appropriate, and should be recognized, when some third-party coverage exists, but it is inadequate

given the financial circumstances of the patient.

Response: We agree, and the regulation has been modified to maintain consistency with Section 1923(b) regarding the calculation of the LIUR. Specifically, CMS recognizes that hospital charity care policy may go beyond individuals with no source of third party coverage and may include underinsured individuals. For purposes of the LIUR only, individuals that qualify under a hospital's charity care policy may be included.

Comment: One commenter stated that this new annual reporting requirement should not be associated to the CMS 64 quarterly report. The commenter suggested that DSH reporting should be submitted directly to CMS on the same day that the required independent certified audit is submitted.

Response: We agree. CMS is not requiring States to submit either the annual report or the certified independent DSH audits in conjunction with the CMS 64 quarterly report. Instead, the annual report and the final audit must be submitted to CMS within 90 days of the completion of the audit. The submissions associated with Medicaid State plan rate year 2005 and 2006 are due no later than December 31, 2009. Each subsequent audit report beginning with Medicaid State plan rate year 2007 must be completed by September 30 of the year ending three years from the Medicaid State plan rate year at issue, and the submissions are due by the following December 31st. This means that the 2007 Medicaid State plan rate year annual report and audit report must be submitted to CMS by December 31, 2010.

Comment: A few commenters state that Federal regulations currently require that hospitals be given the option of qualifying for DSH based on either their Medicaid inpatient utilization rate or their low-income utilization rate, but do not require that hospitals submit information on both of these rates. They stated that the reporting requirements for MUIR and LIUR are not specifically required in the MMA, and do not appear to make a contribution to determining State compliance with the applicable hospital-specific DSH limitation, which is the objective of the proposed regulation according to the MMA. One commenter stated that this reporting requirement for MUIR and LIUR represents another attempt to adopt a substantive policy change in the context of these audit and reporting rules.

Response: The MMA imposes audit and reporting requirements on States regarding DSH payments to eligible hospitals. As part of this process, CMS must ensure if all hospitals receiving DSH payments under the Medicaid State plan actually qualify to receive such payments. Sections 1923(b)(1)(A) and (B) of the Act require that all hospitals with certain threshold MIUR or LIUR levels must be included by the State as DSH eligible hospitals. This is the minimum Federal standard. States have the option to use alternative qualifying criteria that are broader than the minimum Federal standards.

States that use only the LIUR or only the MIUR to determine DSH qualification should report on the statistic utilized in the approved Medicaid State plan for the Medicaid State plan rate year under audit. States using a broader methodology should report the statistic utilized in lieu of the MIUR or LIUR. There is no change in the MIUR or LIUR under this regulation. The statute calls for reporting and auditing of DSH payments, and this rule requires such reporting and auditing, consistent with all existing requirements and limitations associated with those payments. In an effort to provide States with uniform instructions, CMS provided detailed identification of the data elements necessary to comply with these statutory reporting and auditing requirements.

Comment: A few commenters noted that their State's DSH methodology defines Medicaid inpatient utilization differently than does 1923(b)(2). One commenter gave as an example a State that does not include dual eligible days in a hospital's Medicaid utilization rate for DSH purposes, while 1923(b)(2) appears to include these days. The commenter indicated that, using the State-defined Medicaid utilization rate for the eligibility determination, includes more hospitals as DSH providers and pays a higher DSH adjustment than is specified in 1923(c). Another commenter's State utilizes days attributable to dual eligibles to calculate the Medicaid Inpatient Utilization rate (MIUR). Some commenters asked that CMS clarify the standard to be used on whether days attributable to dual eligibles should be included in the calculation of the MIUR for the purposes of determining which hospitals are deemed to be disproportionate share hospitals.

Response: We have revised the regulation to make clear that States that use alternate broader qualifying criteria than the MIUR should report on the hospital's measurement on such criteria. With respect to the statutory MIUR, it is a calculation that includes all Medicaid eligible days. To the extent that an inpatient hospital day for a dually-eligible Medicare/Medicaid patient qualifies as a Medicaid day, that day may be included in the MIUR calculation. States have the option to use alternative qualifying criteria that are broader. States using a broader methodology should report that statistic in lieu of the MIUR or LIUR.

Comment: One commenter said that their State calculates each hospital's MIUR and LIUR for purposes of determining DSH eligibility. The MIUR used for a current year's DSH eligibility is based on data from prior years. The commenter asked for clarification as to whether the MIUR for reporting and audit purposes should be the MIUR used to determine the current year's DSH eligibility, or an MIUR calculated based on the hospitals' current year's operational data. One commenter further questioned whether a State that currently calculates DSH eligibility on a calendar year basis, must now calculate the Medicaid Inpatient Utilization Rate on a State fiscal year basis to comply with the reporting requirements.

Response: The data reported and used in the certified audit should be from the Medicaid State plan rate year. States will continue to have the flexibility to use time periods other than the Medicaid State plan rate year to estimate DSH qualification and DSH payments, but must provide for adjustments to ensure that final qualification and payments are based on actual data for the relevant time period. Consistent with that principle, the LIUR, MIUR or alternative DSH qualifying statistics must be reported in the audit using the actual hospital utilization, payment and cost data applicable to the Medicaid State plan rate year under audit. For instance, if the Medicaid State plan determines DSH qualification in a given year based on prior year Medicaid and/or low-income utilization data, the audit must report that qualifying statistic using actual Medicaid State plan rate year data to demonstrate that the hospital was eligible to receive DSH payments. CMS recognizes that States must use estimates to determine a hospital's DSH qualification and DSH payments in a given year. The regulation is intended to ensure that hospitals are qualified to receive DSH payments and that such payments do not exceed the hospital-specific DSH limit. The transition period, discussed in earlier comments, ensures that States may adjust those estimates prospectively to avoid any immediate adverse fiscal impact.

9. Medicaid Revenues Defined

Comment: A few commenters recognized the importance of the sum of Regular Medicaid Payments, Medicaid Managed Care Organization Payments and Enhanced/Supplemental Medicaid Payments in determining hospital eligibility for Medicaid DSH payments and in calculating the hospital-specific limits for such payments. However, the commenters do not understand why these figures need to be reported separately because those separate figures, in and of themselves, do not contribute to CMS's ability to determine the appropriateness of DSH payments and is not mandated by the MMA.

Response: The statute called for reporting of specific payments and data necessary to ensure the appropriateness those payments, and provides for States to obtain independent certified audits of such payments. The data elements we are requiring are those that we believe are necessary to determine the appropriateness of DSH payments, and to verify audit findings. In an effort to provide States with uniform instructions, CMS provided detailed identification of the data elements necessary to comply with Congressional instruction on such reporting and auditing.

To determine the eligible uncompensated care hospital-specific DSH limit and to ensure that all eligible costs under such limit are offset by total Medicaid payments made, the regulation requires a separate accounting of types of Medicaid payments. The separate reporting of each type of Medicaid payment creates a verification mechanism to ensure that all Medicaid payments are properly offset against the hospital-specific DSH limit. Regular Medicaid payment and supplemental Medicaid payment information is readily available to the State via the Medicaid Management Information System. Information regarding Medicaid managed care payments made to hospitals is available from hospital accounting systems.

Comment: A few commenters did not understand, based on the proposed regulation, whether the categories of "Regular Medicaid payments" and "Medicaid managed care organization payments" are mutually exclusive. Several commenters requested clarification of the phrase, "regular Medicaid payments," stating it is a new term that would benefit from more explicit definition.

Response: We intended in the proposed rule that the terms regular Medicaid payment and Medicaid MCO payments would be mutually exclusive, but because the term "regular" was apparently confusing we are revising the regulatory language to be more specific. We viewed "regular" Medicaid payments as the fee-for-service (FFS) at the base rates that States set for Medicaid services offered through the approved Medicaid State plan. We also included as "regular" Medicaid payments under a FFS rate system any add-ons to rates that account for specific costs. We have now revised the regulation text to identify this category more specifically as IP/OP Medicaid fee-for-service (FFS) basic rate payments.

We distinguish as a separate reporting data element payments to each hospital from MCOs because those payments are derived from different data sources (hospital records). Medicaid MCO payments are payments from MCOs to hospitals for inpatient and outpatient services provided to Medicaid managed care enrollees. We also distinguish as a separate data element supplemental and/or enhanced Medicaid payments that are not part of regular FFS Medicaid rate structure but instead are additional reimbursement to providers above the basic service rate. Supplemental and/or enhanced Medicaid payments are not necessarily available to all participating Medicaid providers and may not be triggered by a claim for Medicaid services provided. A supplemental Medicaid payment may be based solely on qualifying criteria defined in the Medicaid State plan.

Comment: One commenter noted that the regulation specifies how Medicaid MCO payments to hospitals are treated, but does not appear to contemplate the treatment of payments from other managed care entities' that are not solely Medicaid MCOs. The regulations should clarify how all revenues from managed care entities for hospital services should be treated.

Response: Because the regulation specifically addresses Medicaid DSH payments and hospital-specific DSH limits, hospitals will be required to report only the MCO revenues associated with Medicaid inpatient and outpatient hospital services. Only the unreimbursed inpatient hospital and outpatient hospital costs associated with Medicaid managed care (for example, Medicaid shortfall) are eligible to be included in the hospital-specific DSH limit. To determine any eligible Medicaid shortfall, hospitals must include costs associated only with inpatient and outpatient hospital services provided to Medicaid managed care enrollees net of the inpatient and outpatient hospital payments made to the hospital from Medicaid MCOs.

10. Intergovernmental Transfers

Comment: One commenter noted that the proposed rule requirement of reporting transfer payments is not mandated by the MMA. A few commenters requested a definition of the term transfers (§ 447.299(c)(13)), which is undefined in existing Federal statute and regulation. One commenter requested definition and clarification of the phrase, "as a condition of receiving any Medicaid payment or DSH payment."

Response: We have removed this proposed data element because we agree that it is not appropriate in the context of this reporting and auditing obligation, but instead relates to concerns that are better addressed through other oversight procedures. In using the term "transfer," we intended to reference intergovernmental transfer obligations that a DSH hospital may have under a State's Medicaid program. As explained in a response to a subsequent comment, intergovernmental transfer obligations are not considered costs eligible under the hospital-specific DSH limit.

11. Costs Defined

Comment: A few commenters requested a definition of cost indicating that some agencies grant States some leeway in the definition of costs.

Response: Uncompensated care costs eligible under the hospital-specific DSH limit were clearly articulated in the August 26, 2005 proposed regulation. That is, the uncompensated care cost eligible under the hospital-specific DSH limit include the unreimbursed costs of providing inpatient and outpatient hospital services to Medicaid eligible individuals and the unreimbursed costs of providing inpatient and outpatient hospital services to individuals with no source of third party reimbursement for the inpatient and outpatient hospital services they receive. Therefore, all costs for services that are within the definition of inpatient hospital services and outpatient hospital services that are furnished to Medicaid eligible individuals and to individuals with no source of third party reimbursement should be included in calculating the hospital-specific DSH limit. States do not have the flexibility to broaden or narrow the costs included in calculating the hospital-specific DSH limit, because the universe of costs is defined in the statute. States do have the flexibility to vary the level of DSH payment between individual hospitals as long as the payments are at or below the hospital-specific limit. And States are not required to make DSH payments that

cover all costs included in calculating the hospital-specific DSH limit.

Comment: One commenter noted a reference to the cost determination method via the Medicare cost report would be beneficial.

Response: CMS agrees that the same methods used in preparing the Medicare 2552–96 cost report should be applied in determining costs to be used in calculating the DSH hospital-specific limits. We believe that hospitals' Medicare cost report and audited financial statements and accounting records should contain the information necessary for reporting and auditing responsibilities, in combination with information provided by the States' Medicaid Management Information Systems (MMIS) and the approved Medicaid State plan governing the Medicaid payments made during the audit period.

It is important to note that, in using a cost-to-charge ratio in calculating costs, only the inpatient and outpatient hospital charges associated with individuals with no source of third party coverage for such services can be applied to the Medicare cost report for purposes of calculating the uninsured uncompensated care cost component of the hospital-specific DSH limit. Hospitals must also ensure that no duplication of such charges exist in their accounting records. This information must be made available to the auditor for certification.

CMS has developed a General DSH Audit and Reporting Protocol which will be available on the CMS Web site to assist States and auditors in using information from each source identified above to determine uncompensated care costs consistent with the statutory requirements.

Comment: A number of commenters asked for clarification of the requirement in the proposed rule that States should report "separately" the "total annual cost" or the "total annual amount of uncompensated care costs," respectively, "for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individuals and to individuals with no source of third party coverage for the hospital services they receive." The commenters suggested that CMS remove the word "separately" from §§ 447.299(c)(14) and 447.299(c)(15) and clarify that only one data item must be reported for both "total cost of care" and "uncompensated care costs."

Response: The reporting form has been modified to address many comments concerning the necessary data elements to fulfill the audit and reporting requirements. The data element referring to "Total Annual Uncompensated Care Costs" represents the total amount of unreimbursed care to be considered under the hospital-specific DSH limit. This figure is the result of summing "Total Cost of Care Medicaid IP/OP Services" and "Total Cost of IP/OP for uninsured" and then subtracting "Total Medicaid IP/OP Payments" and "IP/OP Uninsured Revenues," and "Total Applicable Section 1011 Payments". The source of this information will be the hospital's Medicare 2552–96 cost reports, hospital audited financial statements and accounting records, and MMIS data.

Comment: Numerous commenters said that a review of the legislative history of the MMA DSH reporting and auditing requirements does not reveal that Congress raised any concerns about the calculation of uncompensated care costs, about how unreimbursed costs were determined for setting the hospital-specific DSH limit by the CMS or State Medicaid programs. Several commenters stated that as a procedural matter, CMS fails to acknowledge that it is changing the definition of a key term, uncompensated care. The new definition is simply included in the preamble and regulation text as though nothing is being substantively changed.

Response: We disagree with the premise of the commenters that the DSH reporting and auditing requirements do not indicate Congressional concern about the appropriateness of DSH payments. And we disagree that this rule changes the definition of uncompensated care that is counted in calculating the hospital-specific DSH limit.

Section 1923(g)(1)(A) of the Act specifics that DSH payments cannot exceed, "the costs incurred during the year of furnishing hospital services (as determined by the Secretary and net of payments under this title, other than under this Section, and by uninsured patients) by the hospital to individuals who either are eligible for medical assistance under the Medicaid State plan or have no health insurance (or other source of third party coverage)". This language plainly identifies the limited population, whose costs were to be included in the calculation, and specifies offset of revenues associated with those costs.

The reporting and auditing requirement, by their nature, indicate concern with the calculation of the hospital-specific limit. In an effort to provide States with uniform instructions, CMS provided detailed identification of the data elements necessary to comply with Congressional instruction on such reporting and auditing. The definitions of the data elements track the statutory language, and do not change the calculation that should have always been performed.

Comment: One commenter states that CMS proposes to redefine uncompensated care costs in a very narrow fashion for DSH reporting, yet for reporting uncompensated care in the Medicare cost report, hospitals are instructed to include bad debts and non-Medicaid indigent care plans. The commenter believes that a uniform definition should be in place for all hospital reporting.

Response: Medicare and Medicaid are separate programs. The Medicare program uses a different, broader, definition of uncompensated care than is authorized for purposes of the Medicaid DSH hospital-specific limit. It is important to note that the statutory provision at Section 1923(g)(1) of the Act does not use the term "uncompensated care" and we use it only because of its longstanding use in this context. The definition we have been using tracks the statutory requirements for the hospital-specific DSH limit.

Comment: One commenter noted that historically, there has been great difference in how uncompensated care costs have been calculated from State to State and asked if this rule would establish a uniform methodology among all States for calculating the uncompensated care costs for Medicaid eligible individuals and individuals with no source of third party coverage. One commenter stated CMS should clarify what amounts (revenue charges and costs) are to be included in uncompensated care.

Response: This regulation sets forth reporting and auditing requirements for DSH payments and necessarily will result in greater uniformity in State practices but this regulation does not change the underlying statutory requirements for DSH payments. In an effort to provide States with uniform instructions, CMS provided detailed identification of the data elements necessary to comply with Congressional instruction on such reporting and auditing.

Comment: One commenter said that public hospitals in their State typically screen uninsured patients to determine the extent of their ability to pay for services rendered. The determination generally results in an allowance that is applied to reduce the amount due from the uninsured patient. The commenter recommends a revision to clarify that discounts for the uninsured are not applied to reduce the hospital's uncompensated care costs. The full cost

should be recognized as uncompensated notwithstanding the discount or allowance process.

Response: We agree that the amount of calculations of uncompensated care should not be reduced by amounts that are not paid because of a provider discounted charge. The statute provides for costs of furnishing services to uninsured patients to be reduced only by the amount of payments received from or for those patients, except for payments for care to indigent patients from a State or unit of local government within a State. We have clarified the data elements in this final rule, and we believe they more clearly track those statutory elements. We note that hospitals may need to ensure that, to the extent that they determine costs based on a cost-to-charge ratio, the unreduced charge is used in the calculation.

Comment: One commenter noted that the "payer discount" exclusion is inappropriate with respect to both the uninsured and Medicaid beneficiaries. With respect to uninsured patients, no third party payer is involved. For services rendered to Medicaid patients, the difference between the Medicaid rates (or Medicaid managed care plan payments) and the costs of furnishing the services constitutes the Medicaid shortfall, that is a component of uncompensated care costs.

Response: As noted above, we agree that payment discounts extended to uninsured individuals should neither increase nor decrease uncompensated care, since offset is required only for actual revenues from or for these individuals. The reference in the proposed regulation was intended to refer to payment discounts extended to health insurers or other third party payers. We have clarified this language in the final rule.

To the extent that hospitals do not separately identify uncompensated care related to services provided to individuals with no source of third party coverage from uncompensated care costs not eligible under the hospital-specific DSH limits, hospitals will need to modify their accounting systems to do so.

Comment: A few commenters stated that contractual allowances and payer discounts for persons with 3rd party coverage are the only items that should not be permissible in this Section. They recommended that the definition of uncompensated care cost be modified to include all uncompensated care costs other than contractual allowances and third party insurance discounts given to plans other than indigent care plans.

Response: As enacted by OBRA 93, the hospital-specific DSH limit is comprised only of the uncompensated care costs of providing inpatient and outpatient hospital services to Medicaid individuals and to individuals with no source of third party coverage for the inpatient and outpatient hospitals services they received.

Comment: One commenter requested clarification of whether the requirement for verifying "The extent to which hospitals in the State have reduced their uncompensated care costs to reflect the total amount of payment adjustments under this Section.", and the new § 455.204(c)(1), should be read to require verification that obligations of the qualifying DSH hospital to fund the non-Federal share of a DSH payment or any other Medicaid payment are not included as uncompensated care costs for purposes of the hospital-specific DSH limit.

Response: The proposed first verification was based on the statutory language of Section 1923(j)(2)(A) of the Act. Since there is no statutory requirement that hospitals actually use DSH payments for uncompenssted care, we are reading this verification to require examination of whether the DSH payments made to each hospital are retained by the hospital and are actually available to offset uncompensated care costs. We have encountered numerous instances in which Medicaid hospital providers are not permitted to retain Medicaid payments for normal hospital purposes. Instead the hospital is required to divert the funding either by returning it to the payor (either directly or indirectly) or is required to use the funding for another purpose. We have revised the wording of this verification to better reflect our reading of its meaning.

We confirm that intergovernmental transfers (IGTs) cannot be included as a cost for purposes of calculating the hospital-specific DSH limit. IGTs are not costs of providing health care services; they are a financing mechanism and should not be included in the calculation of the hospital-specific DSH limits. DSH payments are limited to the costs of providing inpatient and outpatient hospital services to Medicaid eligible individuals and individuals with no source of third party coverage.

Comment: One commenter stated that based on the accompanying discussion found in the **Federal Register**, the State interprets this provision to mean that any amount of funds, certified or transferred by or from a hospital or other governmental entity, that is used to claim Federal DSH funding, must be reported as a DSH payment to the hospital in the evaluation of the hospital-specific DSH limit.

Response: We agree with the reading that Medicaid hospital payments include the total computable federal and non-federal share payment amount, even when the non-federal share is not funded directly by the State Medicaid agency. Certified public expenditures (CPEs) and intergovernmental transfers (IGTs) are non-Federal share funding mechanisms utilized by States to share the cost of financing the Medicaid program with other local government entities, including governmentally operated health care providers. To the extent that governmentally operated health care providers are the source of the non-Federal share funding of a non-DSH Medicaid payment, such sources of non-Federal share become part of the total computable Medicaid payment received by the provider and non-DSH Medicaid payments are a revenue source that offsets costs for purposes of calculating the hospital-specific DSH limit. And to the extent that these mechanisms are used to finance the DSH payments themselves, the total DSH payment would include the total computable expenditure.

It should be noted that IGTs made by hospitals cannot be included as a cost of hospital services under the hospital-specific DSH limit. DSH payments are limited to the costs of providing inpatient and outpatient hospital services to Medicaid eligible individuals and individuals with no source of third part coverage. IGTs are not costs of providing health care services, they are a financing mechanism and should not be included in the calculation of the hospital-specific DSH limits.

CPEs are also a financing method but CPEs are based on actual costs incurred which are certified by a unit of government to represent a Medicaid payment. CPEs by a governmentally operated hospital that represent costs incurred for hospital services for Medicaid-eligible individuals can be included as costs in the hospital-specific limit calculation, but would be completely offset by the Medicaid payments that they represent. When the DSH methodology is based directly on payment for incurred costs of serving the uninsured, CPEs by a governmentally operated hospital may represent the DSH payment. In that instance, the CPE would also represent costs that could be included in the hospital-specific limit, but there would be no payment offset in the calculation. Instead, the total computable amount would be considered as a DSH payment

CPEs by a local government entity that is not a health care provider (when the entity has made a total computable Medicaid payment on behalf of the State

and under the authority of the approved Medicaid State plan) the hospital in receipt of such payment must consider the full amount of that payment as a Medicaid payment that offsets costs in the calculation of the hospital-specific limit.

Comment: Numerous commenters seek clarification that the same methodology for determining uncompensated care costs need not be used for every DSH hospital in the State. They asserted that CMS has previously recognized that any definition of "allowable cost" is acceptable, "as long as the costs determined under such a definition do not exceed the amounts that would be allowable under the Medicare principles of cost reimbursement." The commenters indicated that, in some States, a variety of methodologies may be used to determine the uncompensated care costs for different categories of hospitals, such as public and private hospitals, or for particular hospitals. They suggested that using different methodologies for different hospitals is entirely justified, because not every hospital has the same accounting practices or incurs the same types of costs.

Response: States have considerable discretion to determine allowable inpatient and outpatient costs when determining payment rates under their Medicaid State plan, but Section 1923(g)(1) of the Act provides for a Federal limitation based on costs that must be calculated in accordance with Federal accounting standards. In accordance with this principle, the 1994 guidance provided State flexibility to define Medicaid costs for purposes of setting Medicaid payment rates. But this flexibility does not apply to calculation of hospital-specific DSH limits to the extent that State-defined costs exceed those permitted under Medicare cost principles.

Moreover, the hospital-specific limit is based on the costs incurred for furnishing "hospital services" and does not include costs incurred for services that are outside either the State or Federal definition of inpatient or outpatient hospital services. While States have some flexibility to define the scope of "hospital services," States must use consistent definitions of "hospital services." Hospitals may engage in any number of activities, or may furnish practitioner or other services to patients, that are not within the scope of "hospital services." A State cannot include in calculating the hospital-specific DSH limit cost of services that are not defined under its Medicaid State plan as a Medicaid inpatient or outpatient hospital service.

Comment: One commenter noted that its State agency receives state legislative authority to make distribution to hospitals from general revenue. The State requests confirmation from CMS that these payments, unmatched by Federal funds, are excluded from the hospital's DSH limit calculations.

Response: Section 1923(g)(1)(A) of the Act specifies that, "payments made to a hospital for services provided to indigent patients by a State or a unit of local government within a State, shall not be considered to be a source of third party payment." State or local only, (non-DSH) payments received through an appropriation to the hospital for the provision of indigent care and for which Federal matching funds are not claimed would not be considered a revenue offset for purposes of determining a hospital-specific DSH limit. If, however, the "distributions to hospitals from general revenue" represent DSH payments (or any other Medicaid payment) for which the State will claim Federal matching dollars through the use of certified public expenditures, the State must count the "distributions" as DSH payments (or any other Medicaid payments) for purposes of the audit and report.

Comment: One commenter requests CMS clarify that provider taxes are costs that may be included in a hospital's calculation of its uncompensated care costs.

Response: Existing Medicaid policy recognizes permissible health care taxes as an allowable cost for the purposes of Medicaid reimbursement. A portion of a permissible hospital tax may also be allocated to indigent care days as part of the hospital cost report step-down cost allocation process. Specifically, the portion of a permissible health care related tax allocated to the cost of providing inpatient and outpatient hospital services to patients with no source of third party coverage may be included in the hospital-specific DSH limit.

Comment: One commenter wants to assure hospitals' incurred costs of furnishing services to undocumented aliens are includable in the costs incurred by hospitals for furnishing services to individuals with no source of third party coverage for the services they receive.

Response: The costs of inpatient and outpatient hospital services provided to undocumented aliens with no source of third party coverage for the inpatient and outpatient hospital services they receive are eligible under the hospital-specific DSH limit. These costs must be offset by any payments received by the hospital by or on behalf of the individuals with no source of third party coverage for the inpatient and outpatient hospital services they receive, including the applicable portion of the funding under Section 1011 of the MMA for those Section 1011 eligible aliens with no source of third party coverage for the inpatient and outpatient hospital services they receive or any inpatient and outpatient services not considered eligible under Section 1011. It is important to note that inpatient and outpatient hospital costs related to Section 1011 eligible aliens with a source of third party coverage for the inpatient and outpatient hospital service they receive are not eligible under the hospital-specific DSH limit, as discussed previously.

Comment: Numerous commenters recommended that the language of verification #1 be revised to require that the total amount of claimed DSH expenditures for each hospital that qualifies for a DSH payment in the State is no more than the hospital's uncompensated care costs, exclusive of DSH payments.

Response: The commenters' recommendation appears to reflect the issue that is addressed in the second required verification. The proposed first verification was based on the statutory language of Section 1923(j)(2)(A) of the Act. Since there is no statutory requirement that hospitals actually use DSH payments for uncompensated care, we are reading this verification to require examination of whether the DSH payments made to each hospital are retained by the hospital and are actually available to offset uncompensated care costs. We have encountered numerous instances in which Medicaid hospital providers are not permitted to retain Medicaid payments for normal hospital purposes. Instead the hospital is required to divert the funding either by returning it to the payor (either directly or indirectly) or is required to use the funding for another purpose. We have revised the wording of this verification to better reflect our understanding.

Comment: A few commenters said that in order to ensure timely payments to providers, States should be allowed to continue to use prospective systems to determine uncompensated care costs.

Response: CMS recognizes that States must make prospective DSH payments and that they must estimate eligible hospital uncompensated care costs as part of that process. But, as indicated in numerous audit reports by the HHS Inspector General, such estimates often result in improper payments if not reconciled to actual uncompensated care costs in the rate year. The new statutory reporting and auditing

requirements make clear that such estimates must be reconciled to actual costs in order to apply the statutory hospital-specific limits. As described in responses to comments regarding audit requirements, CMS has clarified that the Medicaid State plan rate years 2005 through 2010 audit findings will be used only for purposes of assisting States in developing estimates for Medicaid State plan rate years 2011 through 2015. As discussed in subsequent comments and applicable regulation text, the 2005 and 2006 audit findings will be used solely to ensure prospective DSH payments do not exceed hospital-specific limits beginning with Medicaid State plan rate year 2011. No retroactive fiscal impact will occur because of the transitional period.

Comment: One commenter had a question about the proposed reporting form, requesting clarification on whether the definition of uncompensated care includes a description of the sources of data used in the calculation as well as a description of the methodology used to calculate uncompensated care cost by the State.

Response: CMS has created a General DSH Audit and Reporting Protocol to provide guidance to states, hospitals, and auditors in the completion of the DSH audit. The total eligible uncompensated care block contained in the reporting form should include, by hospital, the total amount of eligible uncompensated care. This value should be expressed by its dollar value, determined in accordance with the General DSH Audit and Reporting Protocol. This protocol provides general instructions regarding the types and sources of information to be provided to the State and its auditor as well as the calculations the auditor will make based on the data provided. The protocol will be available on the CMS Web site.

Comment: One commenter questioned whether CMS agrees with the method of calculating uncompensated care costs by using the ratio of cost to charges from the hospital's most recent "as filed" cost report and applies this ratio to a twelve-month period of uncompensated charges as reported by the hospital for purposes of completing the reporting form.

Response: The uncompensated care block contained in the reporting form should include, by hospital, the total amount of eligible uncompensated care actually provided during the Medicaid State plan rate year under audit. This value should be expressed by its dollar value and must be based on the actual costs incurred by a hospital and reflected on the Medicare cost report(s) for the period under audit.

CMS has created a General DSH Audit and Reporting Protocol to provide guidance to States, hospitals, and auditors in the completion of the DSH audit. This protocol provides general instructions regarding the types and sources of information to be provided to the State and its auditor as well as the calculations the auditor will make based on the data provided. The protocol will be available on the CMS Web site.

12. Physician Costs

Comment: Several commenters disagreed with the proposed exclusion of physician services from consideration as a cost of hospital services in calculating the hospital-specific DSH limits. They argued that inclusion of such costs is consistent with Federal statute, the legislative history of the statute, and the purpose of the Medicaid Disproportionate Share Hospital Program. Several commenters noted that States have previously relied on the description of "cost of services" contained in a 1994 letter to State Medicaid Directors, which stated that CMS "would permit the State to use the definition of allowable costs in its State plan, or any other definition, as long as the costs determined under such a definition do not exceed the amounts that would be allowable under the Medicare principles of cost reimbursement." Several commenters stated that physician services in a hospital are inseparable from other services furnished to hospital patients. The commenters recommend allowing the uncompensated care costs of hospital-salaried physician services to be included in the calculation of the hospital-specific DSH limit. Many commenters cited correspondence with CMS regarding the inclusion of physician cost as a component of hospital services.

Response: The statute at Section 1923(g)(1) includes in the calculation of the hospital-specific DSH limit the unreimbursed costs of providing inpatient and outpatient "hospital services" furnished to specified populations (Medicaid-eligible and uninsured). Therefore, all costs included must be for services that meet a definition of "hospital services." That is a term that is used elsewhere in the Medicaid statute, in the definition of "medical assistance" at Sections 1905(a)(1) and 1905(2)(A) of the Act, referring to inpatient and outpatient hospital services. Under normal principles of statutory construction and administrative practice, this term should be given a consistent meaning. Thus, we interpret this term under Section 1923(g)(1) of the Act to mean the same as it means under the approved Medicaid State plan description of inpatient hospital services and outpatient hospital services.

Physician services are generally not considered hospital service costs in either Medicare or Medicaid programs, and are recognized as separate costs in the Medicare hospital cost reporting process. Specifically, the physician service costs are generally identified as professional costs and are removed from inpatient and outpatient hospital costs as part of the hospital cost allocation step-down process. The Medicare 2552–96 cost report does not include services furnished by a physician. Physician services are, as a matter of routine, separately billed and reimbursed as a professional service and are not included as part of the inpatient hospital service benefit. Medicaid programs generally follow Medicare payment principles in this respect. Therefore, the uncompensated costs of those services generally cannot be included in the inpatient hospital component of the hospital-specific DSH limit.

In addition, under the Medicaid program, separately reimbursed physician professional services are generally not included in State definitions of outpatient hospital services, but are covered under a separate benefit category. Therefore, the inclusion of separately reimbursed Medicaid physician services in the outpatient hospital service component of the hospital-specific DSH limit would not be allowable because, under the statute, the DSH limit may only include inpatient and outpatient hospital services.

In sum, physician costs that are billed as physician professional services and reimbursed as such should not be considered in calculating the hospital-specific DSH limit, which is comprised only of the unreimbursed costs of providing inpatient and outpatient hospital services to Medicaid and uninsured individuals.

Comment: Many commenters said it was not the intent of Congress to exclude physician costs from DSH limits because Congress expressed the expectation that hospitals receiving DSH payments were responsible for assuring access to physician services, as articulated in the requirement that a DSH facility have at least two obstetricians on its medical staff.

Response: The commenters infer Congressional intent regarding what costs should be included within a

hospital-specific DSH cost limit by referencing a DSH qualification requirement and not the hospital-specific DSH limit requirements. Section 1923(d) specifies requirements for hospitals to qualify for DSH payments. The staff obstetrical requirements are part of the DSH qualification requirements.

Separate treatment of hospital services and professional services has been a longstanding practice that predates the hospital-specific DSH limit and was affirmed by Congress in enacting prospective payment systems for Medicare hospital services. We have to presume that Congress understood what it meant in using the term "hospital services" rather than a more open-ended term. In light of the limited DSH allocations, we read this term to indicate the limited purpose for which Congress elected to make Federal DSH funds available for responsibilities that it may have deemed to be State responsibilities. Since physician services are generally not considered hospital services and the costs of physician services are generally recognized as separate costs in the Medicare hospital cost reporting process, we do not believe that Congress intended to generally include these costs in the hospital-specific DSH limit calculation. To the extent that there are States that have consistent practices of including physician services as an integral part of hospital services for coverage and payment purposes, and does not provide for separate payment (either directly or through an add-on methodology), we would agree that this practice would be applicable in calculating the hospital-specific DSH limit.

Comment: One commenter noted that even Medicare recognizes physician services as hospital services.

Response: This is not correct. Physician services are not generally recognized as hospital service costs in the Medicare hospital cost reporting process. Most physician service costs are identified as professional costs and are removed from inpatient and outpatient hospital costs as part of the hospital cost allocation step-down process. To the extent that there may be some limited exceptions when a physician performs hospital service functions, these exceptions would also be recognized in calculating the hospital-specific DSH limit.

Comment: Numerous commenters stated that exclusion of physician costs from the hospital-specific DSH limit calculation appears to be announcing a new standard/policy, one that is a substantive change in longstanding DSH policy, that is not currently embodied in law, regulation or guidance and that is likely to produce substantial confusion. The commenters stated that this is the first time CMS has suggested that a hospital's legitimate physician costs may never be included in the DSH limit and that this represents a policy reversal by the agency.

Response: This regulation reflects the statutory requirements and existing law and policy. The statute provides for consideration only of the costs of hospital services and the treatment of physician service costs under this rule is consistent with that requirement, with the definition of hospital services generally used by CMS and by States in other contexts. The statute called for reporting and auditing of specific payments and the existing Congressional limitations associated with those payments. In an effort to provide States with uniform instructions, CMS provided detailed identification of the data elements necessary to comply with Congressional instruction on such auditing and reporting.

Comment: A few commenters stated it is inappropriate to address the treatment of physician services in the preamble to this regulation, in light of pending disputes. The commenters asserted that it is improper for the agency to change course unilaterally via one sentence in a preamble, and should not receive deference in any judicial appeals.

Response: This regulation reflects but does not modify existing law regarding the treatment of physician services in the calculation of the hospital-specific limit. CMS has had a consistent position on this issue, and the Departmental Appeals Board issued a decision on May 18, 2007 in one of the pending disputes cited by commenters, in which the Board upheld a disallowance on this basis. Moreover, even if this were regarded as a new or changed policy, the rulemaking process that has been undertaken is an appropriate method for its promulgation.

The issue is rooted in the language of the statute, which at Section 1923(g)(1) refers only to hospital services, and does not include physician services furnished in a hospital. Physician services are not generally regarded as part of hospital services, but are generally regarded as separate professional services. This treatment of physician services has been consistently applied since before the 1993 enactment of the hospital-specific DSH limit.

The data elements identified in the proposed regulation were necessary to ensure compliance with the direction of the statute and those elements represent longstanding CMS policy.

Comment: One commenter stated that their State's Medicaid outpatient payments to hospitals are "bundled," in that the payment includes both a hospital and physician component. Medicaid MCO outpatient payments are similar. Hospitals are unable to separate out the physician-related component of outpatient rates. In order to appropriately match costs to payments for the DSH limit calculations, the commenter believes it is appropriate to include Medicaid outpatient costs related to hospital-based physicians in its DSH limit calculations.

Response: To the extent that a State consistently includes physician services as an integral part of outpatient hospital services and does not make a separate payment for physician services either directly or as an add-on to the hospital rate, we would agree that the State can use the same methodology for calculating the hospital-specific limit. We do not believe this is a customary practice.

With respect to MCO payments, payments by the State to the MCO are not relevant for purposes of the hospital-specific limit. The relevant data elements are hospital costs and revenues associated with inpatient and outpatient services provided to Medicaid MCO enrollees and payments received by the hospital from the MCO for those services. To the extent that the MCO payment combines payment for inpatient and outpatient hospital services with payment for other services, the hospital may need to allocate the revenues based on the ratio of charges for hospital services to total charges, or another reasonable allocation method.

Comment: Many commenters noted that the proposed rule does not prohibit the inclusion of physician costs in the case of salaried physicians employed by the hospital delivering services. If the physician costs are excluded in these circumstances, any hospital that directly employs physicians would be directly impacted by this rule.

Response: This rule does not establish any new principles for the treatment of physician service costs, but requires consistent use of existing hospital accounting principles applicable under Federally supported programs. As noted above, States and hospitals should use a consistent definition of hospital services. Under Medicare, it is not by itself relevant that a hospital pays the salary of a physician; physician services are generally not considered hospital service costs and are recognized as professional fees in the Medicare

hospital cost reporting process. Specifically, the physician service costs are identified as professional costs and are removed from inpatient and outpatient hospital costs as part of the hospital cost allocation step-down process.

In sum, physician costs that are billed as physician professional services and reimbursed as such are not included as hospital services in calculating the hospital-specific DSH limit.

Comment: Several commenters asked about the treatment of physician clinics and other clinic services. They indicated that physician clinics, in both hospital and office settings, focus on primary care to the underserved and function at a financial loss due to inadequate medical reimbursement rates. The commenters recommended that the costs of such clinics be included as hospital services under the hospital-specific DSH limit when services are furnished to Medicaid eligible and uninsured patients.

Response: As indicated above, hospitals and States should use a consistent treatment of physician and other provider-based clinics. All costs that are associated with services that are defined and reimbursed under the approved Medicaid State plan as inpatient hospital services and outpatient hospital services to Medicaid eligible individuals and to individuals with no source of third party coverage for such services may be included in calculating the hospital-specific DSH limit.

Comment: Numerous commenters stated that hospitals, especially critical access hospitals, incur costs to secure the services of physicians to serve the indigent patients, and these costs (fees, contractual agreements or salary costs) should be allowed in the establishment of hospital-specific DSH limits. The commenters indicated that this may be the only way to assure availability of physicians to serve uninsured individuals. They argued that physician costs should not be treated any differently than other costs used to treat the uninsured, particularly when they are incurred to meet EMTALA obligations. They urged that CMS consider expanding the definition of DSH-limit services to include all costs that a hospital incurs providing services to uninsured patients. Otherwise, the purposes of the DSH statute, to assist safety net hospitals and other hospitals to meet their costs of serving the uninsured, would be thwarted.

Response: Section 1923(g)(1)(A) of the Act does not authorize inclusion in the hospital-specific DSH limit of any costs associated with treating Medicaid-eligible and uninsured patients, but specifically authorizes inclusion only of costs of furnishing "hospital services." We understand that there may be a variety of other costs involved in treating uninsured patients, but other costs were not included by Congress. As indicated above, hospitals and States should use a consistent treatment of physician and other provider-based clinics. All costs that are associated with services that are defined and reimbursed under the approved Medicaid State plan as inpatient hospital services and outpatient hospital services to Medicaid eligible individuals and to individuals with no source of third party coverage for such services may be included in calculating the hospital-specific DSH limit.

Comment: One commenter noted that the proposed regulation does not address how physician costs should be treated for DSH purposes for public teaching hospitals that have elected to receive cost-based reimbursement for their physicians as provided for at § 415.160.

Response: Regardless of the reimbursement methodology (cost reimbursement or prospective payment system), uncompensated care costs that may be included in calculating the hospital-specific DSH limit include only the unreimbursed costs of providing inpatient and outpatient hospital services to Medicaid eligible individuals and the unreimbursed costs of providing inpatient and outpatient hospital services to individuals with no source of third party reimbursement. Therefore, all costs defined and reimbursed under the approved Medicaid State plan as inpatient hospital services and outpatient hospital services to Medicaid eligible individuals and to individuals with no source of third party coverage for such services that remain uncompensated reimbursement are eligible under the hospital DSH limit.

Comment: Numerous commenters said that hospitals contract with doctors to perform administrative services such as a Medical Director. This is a direct payment from the hospital to the doctor for "Part A" services and not direct patient care. This portion of physician services should be included.

Response: Because this rule is not devoted to the treatment of physician services as hospital services, we are not going to address every potential arrangement in this rule. As discussed above, physician services are generally not regarded as part of hospital services, but are generally regarded as separate professional services. This treatment of physician services has been consistently applied since before the 1993 enactment of the hospital-specific DSH limit. There are some exceptions to this general principle, and this rule does not change either the general principle or the exceptions. States and hospitals should use a consistent definition of hospital services.

We note that, under Medicare, it is not by itself relevant that a hospital pays the salary of a physician; physician services are generally not considered hospital service costs and are recognized as professional fees in the Medicare hospital cost reporting process. There may be exceptions when a physician is not performing direct patient care and is instead performing general hospital administration functions. When the physician service costs are identified as professional costs, however, they are removed from inpatient and outpatient hospital costs as part of the hospital cost allocation step-down process.

13. Revenues Defined

Comment: One commenter was concerned that a State could lose FFP on its DSH payments to a hospital based on MCO payments that the State does not control. The commenter posed the hypothetical of an MCO, at its sole discretion, being a generous payer to a hospital, and potentially placing the State in jeopardy of losing FFP on DSH payments. The commenter indicated that this did not seem fair when the State does not control the MCO payment. The commenter urged that Medicaid MCO services should be excluded from the uncompensated care costs limit test.

Response: In every State, significant segments of the Medicaid population are served through MCOs. Notwithstanding that delivery system, the costs of serving that population and the revenues received for doing so remain Medicaid costs and revenues to the hospital. Under the statutory hospital-specific DSH limit, it is necessary to calculate the costs of furnishing services to the Medicaid population, including those served by MCOs, and offset those costs with payments received by the hospital for those services. Payments received by the MCO are a necessary part of that statutory calculation. To the extent that hospitals earn profits on Medicaid MCO business, this profit must be offset against other uncompensated costs in the same manner that any Medicaid FFS profits must be offset against other uncompensated costs. Overall, the calculation results in the net uncompensated care in serving the Medicaid and uninsured populations. Disregarding Medicaid MCO revenues

from the hospital-specific DSH limit overstates a hospital's uncompensated care in serving those populations.

Comment: Numerous commenters did not question the general purpose of this requirement, but questioned whether it was fair to limit DSH payments when the Medicaid shortfall is less than projected because of hospital cost controls. These commenters cited the situation in which basic Medicaid payments determined on a prospective basis and individual hospitals are able to control costs sufficiently to earn a profit on their Medicaid business. They argued that requiring that profit to be offset against uncompensated care costs would mean that a hospital that undertakes aggressive cost containment in the end would receive less in total Medicaid revenues than another hospital that forgoes cost containment (and therefore realizes no profit on its basic Medicaid payments) but incurs the same level of unreimbursed uninsured costs. The commenters urge CMS to modify its proposed regulations to provide that for purposes of applying the individual hospital DSH limit, a hospital's costs of serving Medicaid patients will be deemed to be no less than the base payment made to that hospital under a prospective payment system.

Response: Current Federal law expressly demands the offset of all payments under Title XIX other than DSH payments when determining a hospital-specific DSH cost limit. Section 1923(g) states that a DSH payment is inconsistent with the statute, "if the payment adjustment exceeds the costs incurred during the year of furnishing hospital services (as determined by the Secretary and net of payments under this title, other than under this Section, and by uninsured patients) by the hospital to individuals who either are eligible for medical assistance under the Medicaid State plan or have no health insurance (or other source of third party coverage) for services provided during the year." Calculating certain Medicaid costs based on prospective payments received by a hospital does not accurately identify cost and could effectively overstate the hospital-specific DSH limit.

Comment: One commenter questioned whether it is the expectation that hospitals that receive DSH funds that are subsequently passed on to other entities show the gross DSH payment as revenue and the payment to the external entity as an expense.

Response: Payments to hospitals for which Federal matching is claimed are made for specified purposes; either to pay for covered services furnished by the hospital or to account for the costs of serving a disproportionate share of low income patients. To the extent that a hospital is required to pass a Medicaid payment on to another entity, that payment is no longer within those statutory purposes and would be unallowable. In other words, hospitals must retain 100 percent of the total computable DSH payments claimed by States. Any redirection of Medicaid payments (including DSH payments) is inconsistent with the Medicaid statute governing expenditures. For purposes of the hospital-specific limit, DSH payments are not recognized as revenues (because the limit applies to DSH payments, they are not part of the calculation themselves). Finally, non-Federal share obligations to which a hospital is obligated must be transferred prior to receipt of the DSH payment (or any other Medicaid payment) and cannot be included as a cost (expense) eligible under the hospital-specific DSH limit.

Comment: One commenter questioned whether indigent care revenue, as defined, will also include any revenue received by the individual hospital associated with liens (or other such remedies) placed upon an uninsured individual's property or assets? The commenter asked if such revenues (collection from liens and other remedies) would reduce the claimed uncompensated care costs for uninsured individuals during the period in which the revenue is realized (funds received)?

Response: The statutory authority under MMA instructed States to report and audit specific payments and specific costs. In order to accommodate the precise instruction from Congress, States must perform audits associated with defined periods of time and must identify the actual costs incurred and the actual payments received during that defined time period.

CMS received many comments regarding the treatment of revenues received by hospitals by or on behalf of individuals with no source of third party coverage. The comments indicated that often these "self-pay" revenues received in a given year could in fact be related to a prior period. Similarly, CMS received comments regarding the treatment of liens and collections which may occur after an audit is complete but relate to a prior period. Under either circumstance, the hospital would necessarily have received and booked the revenues in a subsequent period. Due to the inability to control these revenue streams and to foster administrative ease, audits should take into account these self-pay revenues (including liens and collections) during the year in which they are received, irrespective of whether such revenues are applicable to a prior period. In other words, the revenue adjustment would be measured during the audit of the Medicaid State plan rate year in which the revenues were received.

14. Timing

Comment: One commenter was concerned that the State is required to indicate the total annual DSH payments made in the audited SFY when DSH payments may be made by the State at a minimum of up to one year after the SFY being reported. The commenter indicated that obtaining the audited SFY DSH payments by the end of the following SFY is not possible for the State.

Response: The statutory authority instructed States to report and audit specific payments and specific costs. Consistent with that provision, States must perform audits associated with defined periods of time and must identify the actual costs incurred and payments received during that defined time period. In order for the audits to properly measure these elements and in consideration of the many comments related to retroactivity and timing issues associated with gathering the data necessary to identify the costs and revenues, CMS has made several revisions to the final rule including identifying that: (i) The Medicaid State plan rate year 2005 is the first time period subject to the audit; and, (ii) the deadline on reporting the audit findings has been extended to at least three full years after the close of the Medicaid State plan rate year subject to audit. Therefore, hospitals would have received all Medicaid and DSH payments associated with that Medicaid State plan rate year.

This three year period accommodates the one-year concern expressed in many comments regarding claims lags and is consistent with the varying cost report period and adjustments. It should be noted that, to the extent that a State makes a retroactive adjustment to non-DSH payments after the completion of the audit for that particular Medicaid State plan rate year, the hospital would necessarily have received and booked the revenues in a subsequent Medicaid State plan rate year. Under these circumstances, the revenue adjustment would be measured during the audit of the Medicaid State plan rate year in which the revenues were received.

Comment: Several commenters indicated the establishment of a State fiscal year reporting timeline may prove problematic because some States currently include in their annual DSH

data collections information from two or more State fiscal years, and then distribute DSH on a Federal fiscal year basis. State fiscal year reporting for DSH may also be inconsistent with a DSH methodology that involves selection of a base year and trending forward.

Response: The auditing and reporting requirements enacted under the MMA supersede prior DSH reporting requirements enacted under the Balanced Budget Act of 1997. This regulation does not require States to implement retrospective DSH methodologies or otherwise change basic approach to DSH payment used by the States. Nor would it require delay in making DSH payments consistent with the authority of the approved Medicaid State plan. CMS recognizes that States may need to estimate uncompensated care to determine DSH payments in an upcoming Medicaid State plan rate year. The regulation is intended to ensure that those estimates are based on the most current final data. Moreover, the regulation will ensure that CMS has the data necessary to determine whether the ultimate DSH payment was consistent with all statutory requirements. Because FFP is only available for proper DSH payments, some States may determine that a retrospective reconciliation is desirable. The transition period in the regulation ensures that States are not adversely impacted retrospectively by the availability of new data resulting from the statutory reporting and auditing requirements.

Comment: One commenter noted that the State reconciles outpatient hospital payments to 72% of cost and the reconciliations may take several years to finalize. How should those reconciliation payments/recoveries be reported?

Response: In consideration of the many comments related to retroactive adjustments and timing issues associated with gathering the data necessary to identify the costs and revenues, CMS has revised the final rule, in part, to identify that the deadline on reporting the audit findings has been extended to at least three full years after the close of the Medicaid State plan rate year subject to audit. By that time, hospitals would have received all Medicaid and DSH payments associated with that Medicaid State plan rate year. This three year period accommodates the one-year concern expressed in many comments regarding claims lags and is consistent with the varying hospital cost report periods and adjustments.

It should be noted that, to the extent that a State makes a retroactive adjustment to non-DSH payments, and that adjustment occurs after the completion of the audit for that particular Medicaid State plan rate year, the hospital would necessarily have received and booked the revenues in a subsequent Medicaid State plan rate year. Under these circumstances, the revenue adjustment would be measured during the audit of the Medicaid State plan rate year in which the revenues were received.

Comment: A few commenters indicated that several reporting requirements under the proposed rule will be of little use without the methodology to show how the reported data yielded DSH payments. The commenters suggested States could highlight the items requested in §§ 447.299(c)(6) through (c)(16) whenever they appear on the pages or worksheets. Putting the requested data in the context of a calculation should help CMS more quickly determine the appropriateness of payment adjustments, as required in the MMA, while simplifying the reporting requirements for the States.

Response: As we gain more experience, we intend to refine and improve the reporting forms. In this rule, we have focused on defining the minimum data elements that are required for analysis of DSH payments. We currently believe that these data elements will provide sufficient information to do so, when considered along with the approved Medicaid State plan and independent certified audits.

Comment: One commenter noted that the proposed rule requires that a State report the payment elements that can be used to determine each hospital's DSH limit payment. In order to avoid undue delays in disbursing needed DSH funds on a timely basis, the commenter suggests it should be acceptable for a State to identify the Medicaid payment amounts based on data collected for a recent prior period, with appropriate adjustments for expected changes between the data collection period and the DSH reporting period. The commenter also asked for clarification as to whether States will need to estimate DSH payments and then do a settlement, or whether DSH payments will need to be retrospective.

Response: This regulation is not intended to require States to implement retrospective DSH methodologies nor delay the making of DSH payments consistent with the authority of the approved Medicaid State plan. CMS recognizes that States must estimate uncompensated care to determine DSH payments in an upcoming year. The regulation will ensure, however that those estimates are based on the most current final data. Moreover, the regulation will ensure that CMS has data necessary to determine whether the ultimate DSH payment was consistent with all statutory requirements. Because FFP is only available for proper DSH payments, some States may determine that a retrospective reconciliation is desirable. The transition period in the regulation ensures that States are not adversely impacted retrospectively by the availability of new data resulting from the statutory reporting and auditing requirements.

Comment: A few commenters said some of these data elements are not available within the specified timeframes. They indicated that, while Medicaid related data is readily available directly to the State, data regarding Medicare payments and discharges and non-Medicaid/non-Medicare data are not readily available to the State in efficient formats and timeframes required by the proposed rule. Moreover, they said that the lag in hospital cost reporting provides States with a very small, possibly unmanageable, window of time to complete and submit the newly required independent certified audit.

Response: Under Section 1923(j) of the Act, States must perform audits associated with defined periods of time. In consideration of the many comments related to timing issues associated with gathering the data necessary to identify the costs and revenues, CMS has revised the final rule to include the following changes, which we believe will afford ample time to obtain final data and analyze that data.

In order to provide for some uniformity in the application of the report and audit requirements among the States, we have identified Medicaid State plan rate year 2005 as the first time period subject to the audit. This revision recognizes that fiscal periods used by hospitals, States and the Federal Government may vary. The Medicaid State plan rate year is a time period defined and used by each State to make DSH payments under the approved Medicaid State plan, and should be the base period for analysis and audit of DSH payments. The statute refers to the reporting and audit requirements applying to "fiscal year 2004 and thereafter", but we are specifying Medicaid State plan rate year 2005 because, in some States Medicaid State plan rate year 2004 may have begun prior to the beginning of Federal fiscal year 2004.

In recognition of potential delays in obtaining needed information, we have extended the period for ongoing report and audit submission until the end of

the Federal fiscal year that is at least three years after the close of the Medicaid State plan rate year. We believe that hospitals would have received most Medicaid, DSH payments, and other payments associated with that Medicaid State plan rate year. This three year period accommodates the concern expressed in many comments regarding claims lags and is consistent with the varying hospital cost report periods and adjustments. And we have provided an additional extension of the time period for the reports and audits for Medicaid State plan rate year 2005 and 2006 which may be concurrently completed by September 30, 2009.

It should be noted that, to the extent that a State makes a retroactive adjustment to the non-DSH payments after the completion of the audit for that particular Medicaid State plan rate year, the hospital would necessarily have received and booked the revenues in a subsequent Medicaid State plan rate year. Under these circumstances, the revenue adjustment would be measured during the audit of the Medicaid State plan rate year in which the revenues were received.

Comment: A few commenters would like clarification as to whether the independent auditor can base certification on the fact that Medicaid losses alone justify the DSH payment, thereby allowing the auditor to ignore uninsured uncompensated care costs in the certification. The commenters recommend for clarity sake that the proposed rule be amended to include a provision granting States the option to not report uninsured costs for some or all hospitals where Medicaid losses justify the DSH payment made.

Response: Most States do not make DSH payments based solely on Medicaid uncompensated care costs. But, as discussed previously, if a State does so, then the State may report only the Medicaid portion of uncompensated care for each hospital, if it obtains from the hospital a certification that the hospital also incurred uncompensated care for individuals who have no health insurance or other third party coverage. When we review certified audit reports submitted by States, we will consider whether more flexibility would be warranted, and we may address the issue in future reporting instructions.

15. Institutions for Mental Disease

Comment: One commenter noted that the proposed rule, under Verification 3, does not reference § 441.40, which provides a definition of an Institution for Mental Disease (IMD). This is problematic since the Social Security Act clearly establishes that IMDs are entitled to participate in Medicaid DSH programs.

Response: We agree with the suggestion that the reporting requirement should include identification of whether the DSH facility is an IMD; we have revised the regulation and reporting form to do so. An additional limit applies to the percentage of the total Federally determined DSH allotment for each State that can be used for payments to IMDs that otherwise qualify for DSH payments under the Medicaid State plan. Identification of whether a DSH facility is an IMD will assist CMS in assessing the appropriateness of the DSH payment.

The IMD limit does not supersede the hospital-specific limit that is the primary focus of the reporting and auditing requirements under this regulation. For purposes of the hospital-specific limit, reporting must take into consideration the Medicaid coverage limitations under Section 1905(a) of the Act, which excludes coverage for patients in an IMD who are under age 65, except for coverage of inpatient psychiatric hospital services for individuals under age 21. For Medicaid-eligible individuals under age 21, or over age 65, uncompensated care costs those eligible individuals would be reported as uncompensated costs for the Medicaid population. For the costs of services provided to those patients between the ages of 22 and 64 who are otherwise eligible for Medicaid, the treatment for the hospital-specific limit may vary based on State practices. Many States remove these individuals from eligibility rolls for administrative convenience (and must reinstate them if they are discharged from the IMD); if so, the costs should be reported as uncompensated care for the uninsured. States that do not remove the individuals from the Medicaid eligibility rolls should report the costs as uncompensated care for the Medicaid population. DSH payments made to IMDs are subject to the same audit and report requirements as all other DSH hospitals to which the State has made payments.

16. Ownership and Type of Hospital

Comment: A few commenters noted that reporting on the type of hospital, type of ownership and the classification of operator is not required under Section 1001 of the MMA. They questioned why CMS proposes such information to be necessary to comply with the reporting requirements included as uncompensated care.

Response: We agree. The regulation and reporting form have been modified to remove the requirement to report the ownership status of a hospital and type of hospital.

C. Auditing

1. General

Comment: Many commenters questioned the ability of the States to actually collect this information and have an independent audit completed within one year after the end of SFY 2005. One commenter said that demanding 2005 cost report data for SFY 2005 also means that most, if not all, of the cost report data forwarded to CMS will be as submitted by the hospitals because the States will not be able to review and audit the cost reports before the reporting deadline.

Response: The information required under the audit is readily available to hospitals and the State based on existing financial and cost reporting tools. As discussed above, we have revised the timing requirements to extend the length of time to submit required reports and audits to permit submission as late as the last day of the Federal fiscal year ending 3 years after the end of the Medicaid State plan rate year, with a special timing provision for the audits for 2005 and 2006, which will be due by December 31, 2009. We believe this accommodates most of these concerns. We also note that we expect that reports and audits will be based on the best available information. If audited Medicare cost reports are not available, the DSH report and audit may need to be based on Medicare cost reports as filed.

Comment: One commenter noted that most of the reporting requirements will require the hospital to report information directly to the State, and requested explanation of the State's due-diligence responsibility for confirmation/assurance of the completeness and accuracy of the data provided by the hospital?

Response: We expect that States will obtain needed information from the hospital's Medicare 2552–96 cost report, audited hospital financial statements, and other hospital accounting records, in combination with information provided by the States' Medicaid Management Information Systems.

Because these source documents are prepared for other purposes, no single document will contain the precise information needed for DSH reporting and auditing purposes. States will need to work with hospitals to develop a methodology that can be applied to these records to properly calculate uncompensated care costs incurred in furnishing hospital services for

individuals without health insurance or other third party coverage. This methodology will need to exclude costs from the calculation costs for services furnished to individuals with third party coverage, prisoners, duplicate accounts, individuals included in calculating the Medicaid shortfall, charges associated with elective procedures, and any professional charges. The methodology must operate in such a way as to provide the State's independent auditor confidence that the data is an accurate representation of the hospital's eligible uncompensated care charge and revenue data.

Comment: A few commenters questioned access to hospital records and other jurisdictional issues. Such access would need to be discussed, decided and clarified for the States. State auditors may not have jurisdiction to audit private hospitals.

Response: States already have authority to obtain the primary data sources needed to complete the DSH audit and the accompanying report. Information can be obtained from existing cost reports and financial information. These documents would include the Medicare 2552–96 cost report, audited hospital financial statements, and hospital accounting records. States and auditors also have access to information from the States' Medicaid Management Information Systems. We expect that States and auditors will need to work with hospitals to develop a methodology that can be applied to these records to properly calculate uncompensated care costs incurred in furnishing hospital services for individuals without health insurance or other third party coverage.

Comment: A few commenters noted that although hospitals submit the newly required S–10 Worksheet (S–10) for their Medicare cost reports, the information required by that Worksheet does not directly parallel the data required in the new reporting requirements. In addition, although both seek determinations of hospitals' total uncompensated care costs, they apply different methodologies for calculating such costs. Thus, DSH recipients will be confronted with making one set of calculations for their annual reports and another for their State's annual DSH report. If States perform calculations with the requested data to determine DSH payments, why not discard (c)(6) through (c)(16), and instead request a copy of DSH payment calculations for all hospitals in a particular fiscal year? Each hospital's payment calculation could appear on separate pages or worksheets.

Response: Worksheet S–10 is not part of the Medicare 2552–96 step-down process used to allocate inpatient and outpatient hospital costs. The cost allocation process utilized in the 2552–96 cost report is considered a key component of determining Medicaid and uninsured hospital costs for purposes of calculating the hospital-specific DSH limit. The Medicare 2552–96 cost report, in conjunction with hospital financial information, including hospital accounting records and Medicaid Management Information Systems data, may be used to determine uncompensated care costs for the calculation of the hospital-specific DSH limits. We expect these calculations to rely primarily on existing information, as outlined in the General DSH Audit and Reporting Protocol that will be available on the CMS Web site. We recognize, however, there may be situations in which the hospital may have to work with the State to develop new data or methodologies to allocate or adjust existing data.

Comment: A few commenters said that currently, there is no one source of data to meet the increased reporting requirements. The sources of data are from various data warehouses and under various State and hospital management systems. The likelihood that data will not be from consistent data sets is possible.

Response: We expect these calculations to rely primarily on existing information, as outlined in the General DSH Audit and Reporting Protocol available on the CMS Web site. We recognize, however, there may be situations in which the hospital may have to work with the State to develop new data or methodologies to allocate or adjust existing data. And it may be necessary for auditors to develop methods to test, verify the accuracy of, and reconcile data from different sources. CMS has developed a General DSH Audit and Reporting Protocol available on the CMS Web site that may assist States and auditors to utilize information from each source identified above and develop the methods under which costs and revenues will be determined.

Comment: One commenter noted that one State Medicaid agency annually surveys all hospitals near the beginning of its fiscal year and hospitals report their data for a twelve month period, but this period does not match the State fiscal year. Further, the commenter noted difficulties in analyzing the data because Federal DSH payments are provided on a Federal fiscal year, and at changing match percentages. Another commenter indicated that another State's DSH payment program operates on a Federal fiscal year basis, which provides consistency with Medicare hospital payment systems, the timing of changes in their Federal financial participation rate and with the timing of their DSH allotment. These commenters noted that the requirement in the proposed regulation for States to report and audit their DSH and enhanced payment programs on a State fiscal year basis will cause significant administrative burden and will not accurately reflect the basis upon which the State is making payments.

Response: We have modified the regulation to indicate the Medicaid State plan rate year as the period subject to the annual audit. The basis for this modification is recognition of varying fiscal periods between hospitals and States. The Medicaid State plan rate year is the period which each State has elected to use for purposes of DSH payments and other payments made in reference to annual limits.

In instances where the hospital financial and cost reporting periods differ from the Medicaid State plan rate year, States and auditors may need to review multiple audited hospital financial reports and cost reports to fully cover the Medicaid State plan rate year under audit. At most, two financial and/or cost reports should provide the appropriate data. The data may need to be allocated based on the months covered by the financial or cost reporting period that are included in the Medicaid State plan period under audit.

CMS has developed a General DSH Audit and Reporting Protocol which will be available on the CMS Web site that may assist States in using the information from each source identified above and developing the methods under which costs and revenues will be determined.

Comment: Several commenters said this would be a reporting burden on Critical Access Hospitals and will distract from needed resources to provide services to the uninsured. One commenter noted that a reporting burden exists because hospitals may not keep self-pay collection logs.

Response: The DSH audit will primarily rely on existing financial and cost reporting tools currently used by all hospitals participating in the Medicare program and therefore, should not generally divert resources necessary to provide services to the uninsured. These documents would include the Medicare 2552–96 cost report, audited hospital financial information, and hospital accounting records in combination with information provided by the States' Medicaid Management Information

Systems and the approved Medicaid State plan governing the Medicaid and DSH payments made during the audit period.

To the extent that hospitals do not separately identify uncompensated care related to services provided to individuals with no source of third party coverage from uncompensated care costs not eligible under the hospital-specific DSH limits, hospitals will need to modify their accounting systems to do so. Setting up an accounting category to aggregate charges and revenues associated with uninsured individuals receiving inpatient and/or outpatient services from a hospital should be an accounting system adjustment not far removed from the process of setting up an account for any other payer category.

For purposes of the initial audits, States and auditors may need to develop methodologies to analyze current audited financial information including hospital accounting records to properly segregate uncompensated costs.

Comment: A few commenters stated the regulation should provide more specificity about the level of precision expected in calculating the total cost of care. They noted that, due to the timing lag for reporting and auditing, some States use the hospital's latest available Medicare cost report to calculate that hospital's overall cost-to-charge ratio. In that instance, the commenters indicated that the State converts the Medicaid and uninsured charges to cost using the hospital's overall cost-to-charge ratio. The commenters also pointed out that relatively few hospitals have a cost reporting period that is the same as the State fiscal year and, therefore, there would be two cost reporting periods during a State fiscal year. The commenters asked if applying a hospital's latest available cost-to-charge ratio to that hospital's Federal fiscal year Medicaid and uninsured charges be an acceptable and reasonable method to calculate that total cost of care.

Response: We expect that State reports and audits will be based on the best available information. If audited Medicare cost reports are not available for each hospital, the DSH report and audit may need to be based on Medicare cost reports as filed. We note that hospitals must follow the cost reporting and apportionment process as prescribed by the Medicare 2552–96 cost report process. To the extent that these cost reports do not contain the precise information needed for the DSH calculation (for example, by not distinguishing the categories of uncompensated care costs that are needed), it may be necessary for hospitals to modify their accounting techniques. In those circumstances, for the initial audits, it will be necessary to review other source materials such as audited hospital financial records and other records, and to develop methodologies to determine the necessary information from such records. We expect States, independent auditors and hospitals to work cooperatively to develop such methodologies.

CMS has developed a General DSH Audit and Reporting Protocol which will be available on the CMS Web site that should assist States and auditors in utilizing information from each source identified above and developing methods to determine uncompensated costs of furnishing hospital services to the Medicaid and uninsured populations.

Comment: One commenter questioned how to identify, "* * * costs incurred for furnishing those services provided to individuals with no source of third party coverage for the inpatient hospital and outpatient hospital services they receive."

Response: CMS has developed a General Audit and Reporting Protocol to provide guidance to States, DSH hospitals and auditors in the completion of the DSH audit. This Protocol includes general instructions regarding the types of information to be provided by hospitals to the State and its auditor as well as the calculations the auditor will make based on the data provided. Specifically, the protocol details the process of using the Medicare 2552–96 cost report, hospital cost to charge ratios and hospital charges for inpatient and outpatient hospital services for which the recipient had no source of third party coverage. The protocol also details the process for determining eligible Medicaid uncompensated care for the Medicaid State plan rate year under audit. The protocol will be available on the CMS Web site.

Comment: One commenter noted that identifying uninsured patients is complicated by the restrictions on which uninsured patient accounts qualify (for example, if one cannot claim accounts denied due to medical necessity issues). This requires a painstaking and time-intensive process of reviewing each account history to identify the reason that an insurance company did not pay.

Response: To the extent that hospitals do not separately identify uncompensated care related to services provided to individuals with no source of third party coverage from uncompensated care costs not eligible under the hospital-specific DSH limits, hospitals will need to modify their accounting systems to do so. Setting up an accounting category to aggregate charges and revenues associated with uninsured individuals receiving inpatient and/or outpatient services from a hospital should be an accounting system adjustment not far removed from the process of setting up an account for any other payer category.

For purposes of the initial audits, States and auditors may need to develop methodologies to analyze current audited financial information, and hospital accounting records to properly segregate and identify DSH eligible uncompensated care costs.

Comment: One commenter noted that a State's Department of Social Services signed a Partnership Plan for the purpose of "establishing a stable funding mechanism for the State's Medicaid program that embodies accountability while assuring the availability of financial resources to provide needed health care to the program's beneficiaries." The commenter noted that additional auditing and reporting requirements, as addressed in the proposed regulation, seem to be unduly burdensome and potentially costly to the State and the hospitals.

Response: Section 1923(j) of the Act contains audit and reporting requirements applicable to all States that make DSH payments. As part of this process, CMS must determine if all hospitals receiving DSH payments under the Medicaid State plan actually qualify to receive such payments and that actual DSH payments do not exceed the hospital-specific DSH limit for the same period.

To the extent that a State makes DSH payments within a Section 1115 waiver demonstration and/or a Partnership Plan, the State is not exempted from the rules surrounding DSH payments, particularly those at 1923(g) of the Act, and the audit and reporting requirements would still apply to that State.

It should be noted that the Partnership Plan primarily addresses funding of the Medicaid program, and is not relevant to the issue of whether particular payments are authorized under the approved Medicaid State plan and may be the basis for FFP under the Federal statute. Funding issues are not the subject of this regulation.

Comment: A few commenters suggested the creation of a $500,000 threshold of DSH payments before an in-depth audit pursuant to 42 CFR 455, new Subpart C is triggered. Many small hospitals have historically low DSH allotments, and the administrative costs

of the proposed DSH reporting and auditing requirements are disproportionately onerous. If this exemption is not possible, the commenters request that any State with a DSH allotment under $500,000 be allowed to use a hospital's independent auditor attestation to meet the audit requirements for hospital data used in DSH calculations. A few commenters suggested that CMS consider evaluating whether the cost associated with detailed audits are justified and whether an audit that reviews a sample of hospitals annually might be just as effective and considerably less costly. One commenter recommended that the requirement be to verify that the State's calculation formula provides for inclusion of only uncompensated care costs of furnishing inpatient and outpatient hospital services to Medicaid eligible individuals and individuals with no source of third party coverage.

Response: There is no statutory authorization for an exception to audit and reporting requirements with respect to hospitals that receive low DSH payments. The audit and reporting requirements under Section 1923(j) of the Act apply to all States that make DSH payments, with respect to each hospital receiving a DSH payment. The statute further requires that CMS obtain information sufficient to verify that such payments are appropriate.

Relying on a sample of cost reports and financial information will not ensure that each DSH payment is appropriate and does not exceed the hospital-specific DSH limit.

The data elements necessary for the State to complete the DSH audit and report should, in part, be information the State already gathers to administer the DSH program. The responsibility of the auditor is to measure DSH payments received by a hospital in a particular year against the eligible uncompensated care costs of that hospital in that same year as determined using the data provided in the cost, utilization and financial reporting documents described above.

Finally, auditing a State's overall DSH payment methodology will not ensure that DSH payments to each hospital do not exceed the statutorily required hospital-specific DSH limit.

Comment: Commenting State Medicaid offices stated that the Medicaid program already represents a huge audit task for their offices, and that adding the additional responsibility of auditing hospital data for each hospital receiving a DSH payment would be an extremely large amount of additional work that would be nearly impossible to fit within required time frames. One commenter said that unless this requirement can be met through the acceptance of evidentiary documentation from the qualifying hospitals, further verification can only be made by the auditors' actual observation of the hospitals' records. The commenter complained that sending auditors to physically visit every qualifying hospital is onerous and expensive and the commenter questioned whether it is CMS' intent to require this extensive a drill-down.

Response: Section 1923(j) of the Act instructs States to audit and report specific payments and specific costs. The responsibility of the auditor is to measure DSH payments received by a hospital in a particular year against the uncompensated care costs for the Medicaid and uninsured populations incurred by that hospital in that same year. The auditor must follow accepted audit standards and develop sufficient confidence in the data to certify the results.

CMS has developed a General DSH Audit and Reporting Protocol to provide guidance to States, DSH hospitals and auditors in the completion of the DSH audit. This protocol provides general instructions regarding the types of information to be provided to the State and its auditor as well as the calculations the auditor will make based on the data provided. The Protocol will be available on the CMS Web site.

Comment: Several commenters noted that a reconciliation that must be completed no later than one year after the completion of each State's fiscal year will place a substantial burden on hospitals. They asserted that this would mean that hospitals will have to provide the State with uncompensated care data for FY 2005 before it is required for the FY 2007 DSH computation. They further indicated that this is not practical, because uninsured patients are difficult to identify until all collection efforts with other payers have been pursued, which can take several years.

Response: As discussed above, we have revised the timing requirements to extend the length of time to submit required reports and audits to permit submission as late as the last day of the Federal fiscal year ending 3 years after the end of the Medicaid State plan rate year, with a special timing provision for the audits for 2005 and 2006, which will be due by December 31, 2009. We believe this accommodates most of these concerns. We also note that we expect that reports and audits will be based on the best available information. If audited Medicare cost reports are not available, the DSH report and audit may need to be based on Medicare cost reports as filed.

Comment: A few commenters said that CMS should not impose unnecessary administrative burdens that will raise costs for * * * hospitals and States (that ultimately will be shared by the Federal Government) that result neither in improved quality or access nor in any measurable gain in accuracy or efficiency, particularly at this time when Congress and the Administration are intently focused on reining in Medicaid expenditures. They argued that diversion of scarce hospital resources from other productive activities to achieve, at best, only marginal gains in accuracy of the uncompensated care cost calculation should be reconsidered. The increased costs outweighing the benefit of the reconciliation mandate.

Response: Section 1923(g)(1)(A) of the Act specifies that DSH payments cannot exceed a hospital-specific limit. Section 1923(j) of the Act, as added by the MMA, instructed States to audit and report DSH payments made by States and compare those payments to the uncompensated care costs as set forth in that hospital-specific DSH limit. This regulation implements those statutory audit and report requirements and is not a discretionary agency action.

We expect that States and auditors will rely on existing financial and cost reporting processes currently used by all hospitals participating in the Medicare program and therefore should not create an undue burden on states and hospitals in reporting compliance with Federal Medicaid law.

CMS has developed a General Audit and Reporting Protocol to provide guidance to States, DSH hospitals and auditors in the completion of the DSH audit. This protocol provides general instructions regarding the types of information to be provided to the State and its auditor as well as the calculations the auditor will make based on the data provided. The Protocol will be available on the CMS Web site.

Comment: One commenter noted that neither the MMA nor the proposed rule clearly state if the independent auditor is providing an opinion on whether the State's calculation formula includes "Only uncompensated care costs of furnishing inpatient and outpatient hospital services to Medicaid eligible individuals and individuals with no source of third party coverage * * *", or whether the intent is for the independent auditor to perform an indepth annual audit of the hospitals records and cost reports in order to verify the hospital reporting processes as well as audit the State's methodology.

One commenter questions whether the requirement is that each State hire an auditor to look at each hospital's uninsured calculations.

Response: Section 1923(j) of the Act, as added by the MMA requires States to audit and report on hospital-specific DSH payments and this rule makes clear that this obligation includes specific cost data. The responsibility of the auditor is to measure DSH payments received by a hospital in a particular year against the eligible uncompensated care costs of that hospital in that same year.

States and auditors will need to obtain data from hospitals and may need to work with hospitals to develop new data or methodologies to allocate or adjust existing data. And it may be necessary for auditors to develop methods to test, verify the accuracy of, and reconcile data from different sources. This audit function is not the same as the function of the hospital's own auditors, however, and would not involve a review of the hospital's financial controls and internal reporting procedures. But the auditors must review the overall methodology for accumulating data to ensure that the resulting data reflects the required elements. In other words, the independent auditors must review the methodology for arriving at hospital-specific data, and must have confidence that the data accurately represents the hospital's eligible uncompensated care costs consistent with the statutory criteria.

Comment: One commenter said that in their State hospital representatives are required to sign a survey of data for DSH purposes, in order to certify that the data is accurate and in accordance with hospital records. There is a requirement that hospitals maintain the supporting documentation for potential audits. The commenter asked if this process was sufficient or whether all the supporting documentation needed to be housed at the Medicaid agency.

Response: Section 1923(j) of the Act requires audit and report of hospital-specific DSH payments and hospital-specific uncompensated care costs. While survey data submitted by the hospital may be an important source of information, the auditors may need to examine the methodology followed to arrive at that survey data, and may need to develop methods to test, verify the accuracy of, and reconcile data from different sources. One ultimate responsibility of the auditor is to compare DSH payments received by a hospital in a particular year with the actual eligible uncompensated care costs incurred by the hospital in that same year. Unreviewed survey data is not sufficient to satisfy the statutory instruction of the MMA.

CMS has developed a General DSH Audit and Reporting Protocol to provide guidance to States, DSH hospitals and auditors in the completion of the DSH audit. This protocol provides general instructions regarding the types of information to be provided to the State and its auditor as well as the calculations the auditor will make based on the data provided. The Protocol will be available on the CMS Web site.

Comment: Many commenters stated that the auditing requirements are costly and burdensome to both the hospitals and the State, creating another source of disincentive to hospital participation. The commenters request CMS be mindful of the additional financial costs that hospitals would incur and compensate hospitals accordingly.

Response: CMS believes that audits will rely primarily on documents already available to hospitals, and thus the audit data burden will neither be significant nor costly. CMS also believes that it is unlikely that a hospital will decline to receive Medicaid DSH payments merely because they must provide information to the State to verify that DSH payments do not exceed the hospital's DSH eligible uncompensated care costs.

Comment: One commenter asked whether the "independent audit" is a financial audit, or an audit of agreed-upon procedures. The commenter indicated that, if it is an audit of agreed-upon procedures, it would be helpful if audit program and procedures clarification were provided by CMS.

Response: The purpose of the audit is to ensure that States make DSH payments under their Medicaid program that are in compliance with Section 1923 of the Act. The nature of the audit encompasses both program and financial elements making it impossible to label as a traditional financial or programmatic/governmental audit.

The audit review of the State's Medicaid program is limited to ensuring that DSH payments are consistent with the approved Medicaid State plan and Federal statutory limits. The DSH audit will rely in part on financial, accounting and cost report data provided by hospitals. This data should be subject to generally accepted accounting principles, and auditors may need to verify the methodology used for calculating such data. These financial elements will demonstrate that Federal payments were claimed in compliance with Federal statutes.

Comment: One commenter's opinion about the most practical manner in which the State could meet this regulation is to require hospitals to expand their current financial audits to include the appropriate hospital-related compliance issues and have their uncompensated care data audited as part of their annual financial statement audit. Auditors of the Medicaid program (as part of the State's Single Audit) could then rely on these audited certifications and evaluate each State's DSH payment calculations and other information being reported by the State to the Secretary.

Response: The statute places audit and reporting requirements upon States, and these regulations reflect those requirements. These regulations do not impede States from developing procedures to meet these requirements that place particular burdens on hospitals receiving DSH payments. For example, States may establish procedures for hospitals to provide detailed audited data that can be relied on by the independent certified DSH auditors. We do not agree that these procedures can completely substitute for an independent certified audit obtained by the State itself. Nor do we agree that the State's single audit can substitute for the DSH audit responsibility under Section 1923(j) of the Act. The purpose of the State's single audit is different from the DSH audit responsibility, and we read the statute to require a distinct, focused review of DSH payments.

Comment: Several commenters recommend that CMS accept the current audit processes of their State. One commenter said that hospitals in the State that are currently required to complete annual certified independent audits of their uncompensated care data are only required to perform audits using generally accepted accounting principles and strongly recommended that the definition be changed so that audits may be performed under those principles already in place for a hospital's audited financial data. The hospitals of some States already independently certify uncompensated care data submitted to the State and submit these audited financial statements along with their annual cost reports. The information in the cost reports comes from the hospitals' accounting systems that have been independently audited. Another commenter recommended that CMS exempt States with satisfactory independent certification programs already in place from this provision.

Response: The statute places audit and reporting requirements upon States, and these regulations reflect those requirements. These regulations do not

impede States from developing procedures to meet these requirements that place particular burdens on hospitals receiving DSH payments. For example, States may establish procedures for hospitals to provide detailed audited data that can be relied on by the independent certified DSH auditors. We do not agree that these procedures can completely substitute for an independent certified audit obtained by the State itself. Nor do we agree that the State's single audit can substitute for the DSH audit responsibility under Section 1923(j) of the Act. The purpose of the State's single audit is different from the DSH audit responsibility, and we read the statute to require a distinct, focused review of DSH payments.

Comment: Numerous commenters noted that the proposed requirement that the audit must be conducted pursuant to the government auditing standards is unduly burdensome. Most auditors in the private sector use generally accepted accounting principles ("GAAP") to audit hospitals' financial data. Thus, the independent auditors involved in performing hospital audits and who use the GAAP standards to do these audits may not even be familiar with the generally accepted government auditing standards. In any case, it is inefficient to require these auditors to perform another audit of the same data using different auditing standards. At a minimum, States or hospitals should be allowed to use either the GAAP standards or the government auditing standards in meeting the audit requirements.

Response: Generally Accepted Government Auditing Standards (GAGAS) are the principles governing audits conducted of government organizations, programs activities, functions or funds. In general, government audits are either performance audits or financial audits. In either type, the focus is on the government entity, its management of a program and/or the financial management and reporting systems associated with that program.

The fact that there are some differences between GAGAS and GAAP, however, is a further reason why hospital audit efforts and the DSH audit have separate focuses and require separate analyses.

The DSH audit and report is a statutorily required component in the administration of the Medicaid program. The purpose of the audit is to ensure that States make DSH payments under their Medicaid program that are in compliance with Section 1923 of the Social Security Act. The audit does not encompass the review of the State's Medicaid program, it simply ensures that one portion of the program is conducted in line with Federal statutory limits. In addition, the DSH audit will rely on financial and cost report data provided by hospitals that are subject to generally accepted accounting principles as part of their primary reporting function.

Comment: One commenter said some auditors may find that base year figures cannot be verified to the extent necessary to provide a valid base because data or audit trails not previously necessary, are now required.

Response: States and auditors will need to obtain data from hospitals and may need to work with hospitals to develop new data or methodologies to allocate or adjust existing data. And it may be necessary for auditors to develop methods to test, verify the accuracy of, and reconcile data from different sources.

Comment: One commenter noted that the proposed rule appears to have greatly expanded the required scope (of Section 1923(j)(2)(E)) by making the State responsible for retaining documentation of patient-specific data. Assuming that CMS does not intend to place such a reporting burden on the States, the commenter requested that CMS clarify that the documentation requirement for hospital-reported data is limited to collecting, documenting and retaining State data and does not include documentation for data that a hospital might otherwise have available.

Response: States and auditors will need to work with hospitals to determine the extent to which original patient-specific source data is required and needs to be retained by the State.

2. Timing of Payments Under Review

Comment: A few commenters questioned whether DSH payments made by a State after SFY 2005 for dates of services prior to SFY 2005 are subject to the new auditing and reporting requirements. They noted that, currently, a few States make DSH payments after receipt of settled cost report from the Medicare fiscal intermediary and applies the DSH allotment based on dates of service. For example, one State made its DSH payment in SFY 2003 for dates of service in 2000 (using the 2000 Federal DSH allotment and settled Medicare cost reports).

Response: Unless otherwise specified in a State plan, the year in which payment is contemplated and accrues (even when subject to adjustment) is the DSH rate year to which it applies. Many States have provisions that provide for DSH payments based on prior year data, but that does not mean that those payments are prior year payments. (In the cited example, if that was the case, then the effect of any change in the DSH payment methodology would take three years to result in payment changes.) Each State should be aware of the Medicaid State plan rate year for which a DSH payment is made.

Comment: A few commenters said while Medicaid related data is readily available directly to the State, data regarding Medicare payments and discharges and non-Medicaid/non-Medicare data is not readily available to the State in efficient formats and timeframes required by the proposed rule.

Response: The commenter specifically questions the availability of non-Medicaid hospital data necessary to complete the audit. The only non-Medicaid related data relevant for the DSH audit would be the inpatient and outpatient hospital charges to individuals with no source of third party coverage. This information is available in hospital accounting records. Since the deadline for reporting the audit findings has been extended to at least three full years after the close of the Medicaid State plan rate year subject to audit, hospitals would have necessarily included this charge data in their as-filed Medicare cost reports.

Comment: One commenter noted it would avoid misunderstanding if CMS clarified whether the required data element refers to gross revenue (full charges for services) or net revenue (expected collections after revenue adjustments.)

Response: Uncompensated care costs under the hospital-specific DSH limit are calculated by reducing costs incurred in furnishing hospital services to the Medicaid and uninsured populations, reduced by revenues received under Medicaid (not including DSH payments) and further reduced by payments received from or on behalf of the uninsured population (not including payments made by a State or local government for services to indigent patients).

Comment: Many commenters recognized that the proposed regulations are effective for SFY 2006 and stated it is inappropriate to require an audit for SFY 2005, when the rule outlining the required data to be audited had only been proposed two months after the close of SFY 2005 (August 26, 2006). The commenters urged a prospective application of these requirements effective for the first State fiscal year that begins after the date the

final rule is issued, to allow sufficient time for respondents to identify data being required and processes to accumulate such data. A few commenters said the proposed regulation is impossible for both States and hospitals from an operational standpoint because this methodology uses actual costs and payments, and because of the deadlines for the audits and reports, neither Medicaid payments nor audited cost information are available. Numerous commenters stated that should CMS require an independent audit, it would be virtually impossible for States to meet the one-year filing deadline.

Response: The statutory provision at Section 1923(j) of the Act requires audits and reports for fiscal year 2004, but we are implementing this provision prospectively with Medicaid State plan rate year 2005, because that is the first Medicaid State plan rate year that necessarily begins in or after Federal fiscal year 2004. With that clarification, and because audits are prospective activities, we do not believe this rule has any retroactive effect. Moreover, as discussed above, CMS has modified the regulation to address the timing concerns expressed by these commenters. The regulation has been modified to:

1. Identify the Medicaid State plan rate year 2005 as the first time period subject to the audit requirement.
2. Extend the time period for submission of completed audit reports to the last day of the Federal fiscal year (FFY) ending three years from the Medicaid State plan rate year under audit. This means that the 2007 Medicaid State plan rate year must be audited by the last day of FFY 2010.
3. Provide for a special transition time period for concurrent completion of Medicaid State plan rate year 2005 and 2006 audits by September 30, 2009.
4. Provide for submission of each audit report within 90 days of the completion of the audit.
5. Provide for a transition period for reliance on audit findings, so that audit findings will not be given weight until Medicaid State plan rate year 2011 and thereafter in calculating uncompensated care cost estimates and associated DSH payments.

Comment: Many commenters said that this requirement could not be met if the regulations required a retrospective audit, because final settlement of hospitals' cost reports is typically contingent upon completion by a Medicare intermediary of audits that can take several years. One commenter noted that the requirement that the certified audit be completed one year after the close of the fiscal year is unattainable because the majority of the data required can only be derived from the Medicaid cost report, which is submitted no sooner than five months after the end of the fiscal year. Given the detail involved in the audit, the commenters indicated that there will not be enough time to receive cost reports, review and settle the reports, and provide data to the auditor, who would need to certify this tentatively settled cost report data for each of the States' DSH providers. One commenter stated that the regulation should be clarified to permit the required report to be based on a hospital's as-filed cost report, and time should be allowed for States to collect the additional data needed to meet the reporting requirements. One commenter said the hospitals in the State accumulate and report costs based on the hospital's fiscal year utilizing the audited Medicare cost report (HCFA–2552–96) which is generally not available before 21 months after the hospital's year end. Moreover, the commenter indicated that such reports do not use the same fiscal year as the SFY, and thus the cost information is not available on a SFY basis. The commenters also indicated that timing issues are also complicated by the fact that Medicaid claims may be submitted by hospitals to the State up to one year after the date of service.

Response: We discussed above the revisions made to address comments on timing issues and extend the time frames for reporting and auditing requirements. We expect that reports and audits will be based on the best available information. If audited Medicare cost reports are not available, the DSH report and audit may need to be based on Medicare cost reports as filed. We recognize that, in many instances, hospital financial and cost report periods will differ from the Medicaid State plan rate year. In these instances, States and auditors may need to use multiple audited financial reports and hospital cost reports (CMS 2552–96, finalized when available or as-filed) to fully document the appropriateness of DSH payments for the Medicaid State plan rate year under audit. The data would then be allocated based on the months covered by the financial or cost reporting period that are within the Medicaid State plan period under audit. For instance, if a Medicaid State plan rate year runs from July 1, 2004 through June 30, 2005, but a DSH hospital receiving payments under the Medicaid State plan operates its financial and cost reporting based on a calendar year, the State and auditors may need to use information from financial and cost reports for calendar years 2004 and 2005. Costs and revenues of serving the Medicaid and uninsured populations would be allocated from each financial and cost reporting period, in this case half from each report, to determine the data for Medicaid State plan rate year 2005.

Comment: One commenter said that due to delays in receiving settled cost reports from Medicare Intermediaries, a State may distribute more than one year of DSH payments to hospitals in a given State Fiscal Year. The commenter asks for confirmation that the State should submit a separate Annual DSH Report for each year of DSH payments, regardless of the date of DSH payment.

Response: The DSH Audit must be performed and reported to CMS on an annual basis, which should reflect the basis for all DSH payments made for the Medicaid State plan rate year, even if the DSH payment for that period is made in a subsequent year.

Comment: A few commenters questioned whether a detailed audit manual should be prepared by CMS in order to assure compliance with the rule when promulgated and to avoid disputes after payments have been made.

Response: CMS has developed a General DSH Audit and Reporting Protocol to provide guidance to States, DSH hospitals and auditors in the completion of the DSH audit. This Protocol includes general instructions regarding the types of information to be provided by hospitals to the State and its auditor as well as the calculations the auditor will make based on the data provided. The Protocol will be available on the CMS Web site.

3. Audit Objective and Data Sources

Comment: Several commenters expressed their opposition to the audit aspect of the proposed regulation. While recognizing the need for audits, the commenters believe that the audits should fulfill only the following three objectives: determine whether individual States are following their own formulas for the calculation of DSH payments and hospital-specific DSH payment limits; verify the accuracy of States' calculations; and determine whether individual States are making good-faith efforts to make those calculations in compliance with Federal guidelines. The commenters believe the proposed regulation exceeds these three objectives. The commenters hope that CMS will instruct auditors that there are, in fact, various ways for States to make these calculations while

remaining in compliance with Federal guidelines.

Response: Section 1923(j) of the Act requires that States audit actual DSH payments made under the approved Medicaid State plan against actual eligible uncompensated hospital costs in the same time period. Hence, the audit requirement necessarily will measure whether DSH payments made under the formulas in the approved Medicaid State plan are within the hospital-specific DSH payment limits as calculated by the State. The Medicaid State plan includes the reimbursement methodologies States utilize to make Medicaid DSH payments. While States typically include a provision within the Medicaid State plan that such payments will not exceed each qualifying hospital's DSH limit, such reimbursement methodologies do not identify cost components that are necessary for calculation of the hospital-specific DSH limits. Instead, States often for payment purposes rely on survey data reported by DSH hospitals to calculate hospital-specific DSH limit, data which is not typically audited by States to ensure compliance with the statutory limits on DSH payments.

While CMS recognizes that States must use estimates to determine DSH payments in a given Medicaid State plan rate year, Section 1923(j) of the Act requires confirmation that such payments do not exceed the cost limitations imposed by Congress under the Omnibus Budget Reconciliation Act of 1993.

Comment: A few commenters suggested the regulation should clarify the source for the information to be provided for the audit, particularly as it pertains to the payments made for the services. The commenters specifically asked whether the information should be on discharges during a State fiscal year (Medicare pays based on discharges), admissions during a State fiscal year (some States pay based on admissions), or actual payments made during the State fiscal year regardless of when the services were provided.

Response: Section 1923(j) of the Act requires states to report and audit hospital-specific DSH payments and hospital-specific uncompensated care costs. To meet this requirement, States must perform audits associated with defined periods of time and must identify the actual costs incurred and payments received during that defined time period.

As noted previously, we expect that States and auditors will obtain information whenever possible from existing sources. States and auditors should use consistent practices in their reports and audits. Because each State uses different hospital payment methodologies, there is no national rule on whether, for example, admissions or discharges should be used to measure whether services were furnished within a Medicaid State plan rate year. The same methodology should be used to measure uncompensated care costs as is used in determining payments under the Medicaid State plan.

CMS has developed a General DSH Audit and Reporting Protocol will be available on the CMS Web site to assist States and auditors in developing methodologies to use existing sources of information to determine uncompensated care costs in furnishing hospital services to the Medicaid and uninsured populations.

Comment: A few commenters stated they currently have no way of verifying payments to hospitals by Medicaid managed care organizations for inpatient and outpatient hospital services furnished to Medicaid eligible individuals because payments to hospitals are paid directly by the managed care plans. The commenters indicated that States have no first hand knowledge, and no claims documentation regarding these payments. The commenters questioned whether CMS would accept the use of self-reported hospital financial information that references these payments in total for purposes of the Annual DSH Reports.

Response: There are three specific types of revenues that must be included in the audit to which the State conducting the audit will not have direct access. They are: (1) Medicaid and DSH payments received by the hospital from a State other than the State in which the hospital is located; (2) Medicaid MCO payments; and, (3) uninsured payments. The State must rely on hospital audited financial statements and hospital accounting records for this information. The State's Medicaid Management Information System has the most central and current information for in-State Medicaid fee-for-service inpatient and outpatient hospital payments, Medicaid supplemental and enhanced payments and DSH payments and will be the source of such payment.

In addition, hospital cost information is available only from a reporting DSH hospital. The State and CMS must rely on hospital Medicare 2552–96 cost reports to provide this information.

Comment: One commenter requested CMS clarify that it is acceptable to report data for a recent prior period, with appropriate adjustments for expected changes between the data collection period and the DSH reporting period.

Response: We read the report and audit requirements to call for actual data, rather than estimated data. To accommodate the delays in obtaining data, we have extended the deadlines for submission of the reports and audits. While CMS recognizes that States must use estimates to determine initial DSH payments in a given Medicaid State plan rate year, Section 1923(j) of the Act requires confirmation that such payments do not exceed the cost limitations imposed by Congress under the Omnibus Budget Reconciliation Act of 1993. We do not believe estimates are sufficient to meet this requirement.

Comment: One commenter questioned the ramifications of reporting costs and payments in out-of-State and border hospitals, and asked whether the audit team would be responsible for DSH amounts for only hospitals in the State or for all hospitals (in State and out of State) that received Medicaid DSH dollars from that State. The commenter suggested that, in order to avoid duplicate payments, CMS should outline a methodology to be utilized when auditing hospitals that receive DSH payments from more than one State.

Response: A State is required to audit DSH payments and eligible uncompensated care costs for only those DSH hospitals that are located within the State. This method will allow the auditor to recognize DSH payments received by a hospital from other States in addition to the DSH payments received by that hospital under the "home-State's" approved Medicaid State plan.

For States that make DSH payments to hospitals located in other States, the State must include in the reporting requirements the DSH payments made to hospitals located outside of the State, but would not be required to audit those out-of-State DSH hospital's total DSH payments/total eligible uncompensated care costs. This method will ensure that no DSH hospital is audited more than one time per year for purposes of the DSH auditing and reporting requirements under the MMA.

Comment: Many commenters noted that the DSH program has allowed hospitals to extend access to healthcare for many poor and uninsured individuals. They noted that the new requirements include significant administrative expenses and responsibilities to both the States and hospitals. Several State Medicaid Agencies were concerned that a likely outcome will be that hospitals decline to participate in the DSH program,

resulting in a decline in the delivery of healthcare services to the uninsured citizens and the patients treated from some Indian Reservations.

Response: CMS does not believe that the audit data burden will be significant since the audit relies on documents already available to hospitals. CMS also believes that it is unlikely a hospital will decline to receive Medicaid DSH payments for uncompensated care simply because the hospital must provide information to the State to assist in the verification that DSH payments do not exceed the hospital's eligible uncompensated care costs as required by Federal law.

The State is responsible for the administration of its Medicaid program and the successful completion of the DSH audit as part of that administration. Costs associated with the audit are eligible for Federal administrative matching funds.

Comment: Many commenters stated it would be extremely labor intensive and an excessive reporting burden for (DSH) hospitals to match payments received from individuals to payments received for individuals for which there was no third party coverage because it does not currently do that automatically.

Response: To the extent that hospitals do not separately identify uncompensated care related to services provided to individuals with no source of third party coverage for the inpatient and outpatient hospital services they receive from uncompensated care costs not eligible under the hospital-specific DSH limits, hospitals will need to modify their accounting systems prospectively to do so. Setting up an accounting category to aggregate charges and revenues associated with uninsured individuals receiving inpatient and/or outpatient services from a hospital should be an accounting system adjustment not far removed from the process of setting up an account for any other payer category.

For purposes of the initial audits, States and auditors may need to develop methodologies to analyze current audited hospital financial statements and hospital accounting records to properly segregate uncompensated costs.

Comment: Many commenters have stated that it is unclear who must pay for the audit.

Response: The DSH audit and report is a necessary element in the administration of the Medicaid program. The cost of the audit is the responsibility of the State and can be matched by the Federal Government as a Medicaid administrative cost of the State.

Comment: Several commenters noted the proposed requirement for the independent certified audits is unduly burdensome. Several States have had in place for a number of years a requirement that hospitals submit certified public audit or certifications of hospitals' uncompensated care data. This is followed by the single State audit of State's DSH program which tests and verifies all of the elements that are currently required by the DSH state plan and State law requirements. To impose an additional layer of auditing at considerable expense to States is unnecessary.

Response: Section 1923(j) of the Act requires States to audit actual DSH payments made under the approved Medicaid State plan against actual eligible uncompensated hospital costs in the same time period. Hence, the audit requirement will necessarily measure whether payments made under the formulas in the approved Medicaid State plan are within the hospital-specific DSH payment limits as calculated by the State. The certification required in the regulation is a certification of the audit performed to determine compliance with the hospital-specific limitations imposed by Section 1923 of the Act.

While the DSH audit will rely on existing financial and cost reporting tools currently used by all hospitals participating in the Medicare program including audited hospital financial statements, hospital accounting records and the Medicare 2552–96 cost report, these source documents simply provide data to the auditor. Certification of these source documents is not sufficient to ensure that DSH payments do not exceed the hospital-specific limits and would not allow CMS to carry out the intent of the law which was to ensure that each DSH hospital will not exceed its hospital-specific limit. The independent certified audit will verify that the DSH payments authorized under the approved Medicaid State plan are within the hospital-specific DSH limits defined under Federal law.

Comment: Several commenters requested clarification regarding who is responsible for obtaining the independent audit and ensuring the requirements are met. For example, it could be presumed that these audit requirements are the responsibility of the State's auditor, the State Medicaid program's auditor, the Medicaid agency's staff or their agent, or the hospital's auditor.

A few commenters said it is not clear what constitutes "independent," and propose that CMS consider "independent audit" to mean an audit independent of the hospital that does not require the State to contract with a private-sector auditing firm to complete and certify. One commenter questioned whether the terms in the rule stating that the audit must be independent and certified presumes that a certified public accountant or comparable professional must perform the audit or is the State allowed to engage the services of a contractor with different skill sets as long as the auditor is independent? One commenter questioned whether "independent audit" means that a State may employ its current outside auditors to conduct audit and reporting requirements required by the proposed regulations, recognizing that audit programs will be modified to meet the additional auditing and reporting requirements demanded?

Response: The term "independent" means that the Single State Audit Agency or any other CPA firm that operates independently from either the Medicaid agency (or other agency making Medicaid payments) or the subject hospital(s) may perform the DSH audit. States may not rely on non-CPA firms, fiscal intermediaries, independent certification programs currently in place to audit uncompensated care costs, nor expand audits of hospital financial statements to obtain audit certification of the hospital-specific DSH limits.

Section 1923(j) of the Act requires States to report and audit specific payments and specific costs. The responsibility of the auditor is to measure DSH payments received by a hospital in a particular year against the eligible uncompensated care costs of that hospital in that same year. Certification means that the independent auditor engaged by the State reviews the criteria of the Federal audit regulation and completes the verification, calculations and report under the professional rules and generally accepted standards of audit practice. This certification would include a review of the State's audit protocol to ensure that the Federal regulation is satisfied, an opinion for each verification detailed in the regulation, a determination of whether or not the State made DSH payments that exceeded any hospital's specific DSH limit in the Medicaid State plan rate year under audit. The certification should also identify any data issues or other caveats that the auditor identifies as impacting the results of the audit.

Comment: Several commenters believe the most practical manner in which the State could meet this audit regulation is by requiring hospitals to have their uncompensated care data

audited as part of their annual financial statement audit. Auditors of the Medicaid program (as part of the State's Single Audit) could then rely on these audited certifications and evaluate each State's DSH payment calculations and other information being reported by the State to the Secretary. Numerous commenters stated it would be more efficient and less burdensome for the individual hospitals to make the required verifications for their own financial data. Most hospitals already have their financial information reviewed and certified by an independent auditor, so the auditor could complete these verifications as part of the standard audit process. One commenter stated it is not clear if audit procedures applied in any other audits the hospital has undergone would be sufficient to rely upon in this verification. One commenter suggests that data submitted by a hospital which has had its own independent audit be considered "certified" for the independent audit requirements of this rule.

Response: States may not rely on independent certification programs currently in place to audit uncompensated care costs nor expand audits of hospital financial statements to obtain audit certification of the hospital-specific DSH limits. Section 1923(j) of the Act MMA imposes audit and reporting requirements on States. CMS must determine if all hospitals receiving DSH payments under the Medicaid State plan actually qualify to receive such payments and that actual DSH payments do not exceed the hospital-specific limit for the same period. The certification required in the regulation is a certification of the audit performed to determine compliance with Section 1923 of the Social Security Act.

While the DSH audit will rely on existing financial and cost reporting tools currently used by all hospitals participating in the Medicare program including audited hospital financial statements, hospital accounting records, and the Medicare 2552–96 hospital cost report, these source documents simply provide data to the auditor. Certification of source documents or uncompensated care cost programs is not sufficient to ensure that DSH payments do not exceed the hospital-specific limits and would not allow CMS to carry out the intent of the law which was to ensure that each DSH hospital will not exceed its hospital-specific limits.

Comment: Several commenters indicated that most of the requirements outlined in the proposed regulations require data that will be obtained from hospital cost reports. The commenters questioned whether the States will be responsible for completing individual hospital audits in greater detail prior to completing the DSH report. One commenter questioned whether having the data audited by an independent audit firm engaged by the DSH hospitals would satisfy the independent audit requirement, or whether States would be required to audit the data?

Response: We anticipate that the audit will rely primarily on already available documents. The State and auditors can use data extracted from existing hospital cost and financial reporting tools supplemented with State generated data from the State's Medicaid Management Information System. The data elements necessary for the State to complete the DSH audit and report should, in part, be information the State already gathers to administer the DSH program.

States and auditors will need to obtain data from hospitals and may need to work with hospitals to develop new data or methodologies to allocate or adjust existing data. And it may be necessary for auditors to develop methods to test, verify the accuracy of, and reconcile data from different sources. This audit function is not the same as the function of the hospital's own auditors, however, and would not involve a review of the hospital's financial controls and internal reporting procedures. But the auditors must review the overall methodology for accumulating data to ensure that the resulting data reflects the required elements. In other words, the independent auditors must review the methodology for arriving at hospital-specific data, and must have confidence that the data accurately represents the hospital's eligible uncompensated care costs consistent with the statutory criteria.

Comment: A few commenters indicated that many States have invested an increasing amount of time and expense managing Federal audits and presumed the increased audit requirements would be at the States' expense.

Response: CMS does not believe the audit data burden will be that significant since the audit may rely primarily on already available documents. The State and auditors can use data extracted from existing hospital cost and financial reporting tools supplemented with State generated data from the State's Medicaid Management Information System. The data elements necessary for the State to complete the DSH audit and report should, in part, be information the State already gathers to administer the DSH program. The State would incur additional cost associated with engaging an auditor but that cost is eligible for Federal administrative matching funds.

Comment: One commenter stated that using an independent auditor would add administrative costs to the Medicaid program. The State requests CMS to confirm if DSH funds can be used to fund the cost of the audit, and if the State can claim FFP at the DSH matching rate.

Response: State costs of the audit are administrative costs of the Medicaid program, and not DSH costs. The DSH program was established by Congress to help offset uncompensated inpatient and outpatient care provided by hospitals to Medicaid individuals and the uninsured. States may not access Federal DSH funding for purposes other than reimbursing hospitals for unreimbursed inpatient and outpatient services provided to Medicaid individuals and individuals with no source of third party coverage for the inpatient and outpatient hospital services they received.

The DSH audit and report is a necessary element in the administration of the Medicaid program. The State is responsible for the successful completion of the DSH audit as part of that administration. Costs associated with the audit are eligible for Federal administrative matching funds.

Comment: Numerous commenters noted that the proposed rule does not address how the audits will be paid for and there is a concern that the State Medicaid programs will pass on these additional costs to DSH hospitals. The commenters recommended that CMS state affirmatively that the cost of the audits should not be passed on to hospitals. A few commenters noted that since the cost of auditing each DSH hospital's records to satisfy the new audit requirements will be substantial and recommended it be funded by a special appropriation to the States for such purpose. Many commenters recommended that CMS reconsider its conclusion that the regulation would not have a significant economic impact and should undertake appropriate analyses under Executive Order 12866 and the regulatory impact analysis to consider how the burden on hospitals could be lessened.

Response: We still do not believe that this regulation will impose a significant impact. The final rule allows the DSH audits to be part of a hospital's existing annual financial. If this is the case, the costs to the hospital should be minimal since the annual hospital financial audit is already a requirement. States are responsible for the administration of their Medicaid programs and the

REQUEST FOR QUOTATION

[MED13004] [Audit Services – Disproportionate Share Hospital Program]

successful completion of the DSH audit as part of that administration.

Comment: Numerous commenters indicated significant confusion regarding the mechanics of compliance with the requirement for States to have DSH payment programs independently audited annually and to submit those certifications annually to the DHHS Secretary. The commenters requested further guidance and explicit details of standards and procedures required by CMS.

Response: As a condition of continued Federal DSH funding, pursuant to §455.204, States will need to be in compliance with audit and reporting requirements. CMS has developed a General DSH Audit and Reporting Protocol which will be available on the CMS Web site to assist States and auditors in utilizing information from each source identified above and the methods under which costs and revenues will be determined. In addition, an auditing and reporting schedule is described in earlier responses to comments and is also included in the final regulation.

Comment: A few commenters noted that their States have experienced numerous difficulties when contracting with external auditing firms. Subjecting each hospital's DSH data to another audit at the State level would be an extremely time-consuming and very expensive process for the State would not add any value to the auditing process.

Response: The DSH audit and report is a necessary element in the administration of the Medicaid program. The State is responsible for the successful completion of the DSH audit as part of that administration. Costs associated with the audit are eligible for Federal administrative matching funds.

The term "independent" means that the Single State Audit Agency or any other CPA firm that operates independently from the Medicaid agency and the subject hospitals may perform the DSH audit. States may not rely on non-CPA firms, fiscal intermediaries acting as agents for a State's Medicaid program, independent certification programs currently in place to audit uncompensated care costs, nor expand hospital financial statements to obtain audit certification of the hospital-specific DSH limits.

States may use Medicaid agency auditors to gather the data and perform initial data analysis for the DSH audit. However, the audit must be certified by an independent auditor as described above.

Comment: One commenter questioned whether it is CMS' intent to prevent an independent CPA firm, contracted by a State to audit Medicaid cost reports on the State's behalf, from being able to audit that same state's DSH program through the independence requirements of the Government Auditing Standards. If so, the commenter questioned if any contract with a State's Medicaid agency would impair the independence of a CPA firm in performing the DSH audit required in the rule.

Response: The intent of the requirement that States use independent auditors to certify the DSH audit is to provide a quality end product based on consistently applied auditing standards to produce unbiased findings. An independent auditor must operate independently from the Medicaid agency and the subject hospitals. The fact that a CPA firm contracts with the Medicaid agency to audit Medicaid cost reports does not disqualify that firm from being considered independent and therefore qualified to perform the DSH audit as long as the contract permits the auditor to exercise independent judgment.

Comment: Many commenters questioned whether the State audit agency would be appropriate for a certified independent audit according to generally accepted government auditing standards. If an independent audit of each facility is required, the commenters asked if State Medicaid program auditors would be considered independent to perform the hospital portion of the work.

Response: The term "independent" means that the Single State Audit Agency or any other CPA firm that operates independently from the Medicaid agency or subject hospitals is eligible to perform the DSH audit. States may not rely on non-CPA firms, fiscal intermediaries acting as Agents for a State's Medicaid program, independent certification programs currently in place to audit uncompensated care costs, nor expand hospital financial statements to obtain audit certification of the hospital-specific DSH limits.

States may use Medicaid agency auditors to gather the data and perform initial data analysis for the DSH audit. However, the audit must be certified by an independent auditor as described above.

Comment: A few commenters stated that the financial effectiveness of the audits would be enhanced if the Medicare fiscal intermediaries were available to do the audits. Intermediaries provide services at a lower cost than private accounting firms. Time world be saved because the intermediaries have all the necessary information. This may also be helpful to States that require a lengthy procurement bidding process.

Response: States may contract with Medicare fiscal intermediaries to the extent that the Medicare fiscal intermediary meets the definition of an independent CPA firm and operates under a contract that ensures independent judgment. The term "independent" means that the Single State Audit Agency or any other CPA firm operates independently from the Medicaid agency or subject hospitals.

Comment: One commenter questioned whether it would be appropriate for the State's Auditor General's office to perform the independent audit of DSH Payments using the Generally Accepted Government Auditing Standards.

Response: The term "independent" means that the Single State Audit Agency or any other CPA firm that operates independently from the Medicaid agency or subject hospital may be qualified to perform the DSH audit.

Generally Accepted Government Auditing Standards are the principles governing audits conducted of government organizations, programs activities, functions or funds. In general, government audits are either performance audits or financial audits. In either type, the focus is on the government entity, its management of a program and/or the financial management and reporting systems associated with that program.

The DSH audit and report is a necessary part of the administration of the Medicaid program. The purpose of the audit is to ensure that States make DSH payments under their Medicaid program that are in compliance with Section 1923 of the Act. The audit does not encompass the review of the State's overall Medicaid program, it simply ensures that one portion of the program is conducted in line with Federal statutory limits. In addition, the DSH audit will rely on financial and cost report data provided by hospitals that are subject to generally accepted accounting principles as part of their primary reporting function.

Comment: Many commenters expressed concern for the financial stability of disproportionate share hospitals and States and their requirement for finality, with respect to prior year DSH payment determinations. They asserted that allowing States to make good-faith efforts to estimate hospital-specific DSH payment limits, so long as States are using the most recently available data, would help prevent situations in which States would need to attempt to take back past DSH payments to hospitals—a situation

that would be especially burdensome for the very kinds of hospitals that DSH payments are intended to help. One commenter stated that the new rules impose an extremely heavy penalty on certain small hospitals. That commenter indicated that it would be unlikely that these hospitals could repay any amounts to the Medicaid program from current operating income.

Response: We recognize that States must use estimates to determine DSH payments in a given year. The regulation will provide information that will help ensure that the actual DSH payment made by States based on those estimates do not exceed the actual eligible uncompensated costs under the hospital-specific DSH limit. The transition period included in this regulation ensures that States will have time to adjust those estimates prospectively.

Comment: Numerous commenters did not see how the verification requirement could be completed without an additional annual cost report for an annual period that differs from its established fiscal year cost reporting period and an additional audit that would tie the hospital costs to the State year-end versus hospital year end and DSH payments with the same year actual uncompensated care costs. They asserted that the verification requirement is an extraordinary unreasonable and completely unnecessary administrative and economic burden on hospitals and States due to time-consuming, costly, and often duplicative audits. Many critical access hospitals do not have the excess manpower and resources to accomplish this additional audit. In many States, it disturbs an effective and efficient system that already meets Federal standards for program integrity.

Response: The DSH audit will rely on existing financial and cost reporting tools currently used by all hospitals participating in the Medicare program. We expect that State reports and audits will be based on the best available information. If audited Medicare cost reports are not available for each hospital, the DSH report and audit may need to be based on Medicare cost reports as filed. CMS does not believe that the audit data burden will be significant since the audit relies on documents already available to hospitals.

Comment: Many commenters noted that it would be an administrative burden to perform retrospective reviews and adjust each year's DSH payments. Therefore, the commenters request that CMS audit the data used by the State to determine the prospective DSH payments paid during the State fiscal year based upon the CMS approved DSH State plan payment methodology to determine the actual uncompensated care costs in the same audited SFY.

Response: Section 1923(j) of the Act imposes audit and reporting requirements on all States that make DSH payments to all DSH eligible hospitals within the State. As part of this process, CMS must determine if all hospitals receiving DSH payments under the Medicaid State plan actually qualify to receive such payments and that actual DSH payments made do not exceed the hospital-specific DSH limit for the same period.

DSH payments are limited by Federal law to each qualifying hospital's specific eligible uncompensated care cost in a given year. Auditing a State's DSH payment methodology will not ensure that DSH payments actually made by States do not exceed the statutorily required hospital-specific DSH limit. Verifying cost elements within a DSH payment methodology would not allow CMS to carry out the intent of the law which was to ensure that each DSH hospital will not exceed its hospital-specific DSH limit.

Comment: One commenter said Verification 3 would be a burden on the State. Another commenter stated that the requirements in Verification 3 would dictate significant additional work by the independent auditor (and added cost to the State and Federal governments) for unnecessary data analysis.

Response: CMS does not believe that Verification 3 in the regulation will create significant additional work for the independent auditor nor the States. The auditor engaged by a State to complete the DSH audit must rely on information provided by the State and DSH hospitals. This information will be based on existing financial and cost reporting tools as well as information provided by the State's Medicaid Management Information System and the existing approved Medicaid State plan. DSH hospitals must provide the State with hospital-specific cost and revenue data, including backup documentation, so that independent auditor may utilize in developing audit report. The State must provide the auditor with information pertaining to the Medicaid State plan DSH payment methodologies and the methodology utilized by the State uses to estimate the hospital-specific DSH limits.

CMS has developed a General DSH Audit and Reporting Protocol to provide guidance to States, DSH hospitals and auditors in the completion of the DSH audit. This Protocol includes general instructions regarding the types of information to be provided by hospitals to the State and its auditor as well as the calculations the auditor will make based on the data provided. The Protocol will be available on the CMS Web site.

The DSH audit and report is a necessary element in the administration of the Medicaid program. The cost of the audit is the responsibility of the State and can be matched by the Federal government as a Medicaid administrative cost of the State.

Comment: One commenter questioned whether it is CMS' intent that the term "appropriate" indicates documentation that has been verified and/or audited. The vagueness of the term may also make it difficult for an independent auditor to provide an opinion. As an alternative, and assuming that all other requirements will be clearly defined, the commenter recommends that CMS consider an alternative that a State employs a methodology for calculating the hospital-specific DSH limit that is permissible under Federal rules.

Response: The statutory process requires examination of whether all hospitals receiving DSH payments under the Medicaid State plan actually qualify to receive such payments and whether actual DSH payments made are within the hospital-specific DSH limit for the same period. DSH payments are limited by Federal law to each qualifying hospital's specific eligible uncompensated care cost limit. Several audits by the Inspector General have highlighted the need for greater scrutiny and have indicated that calculations performed by State agencies or hospitals are not reliable.

Concerning the degree of data verification required, States and auditors will need to obtain data from hospitals and may need to work with hospitals to develop new data or methodologies to allocate or adjust existing data. And it may be necessary for auditors to develop methods to test, verify the accuracy of, and reconcile data from different sources. This audit function is not the same as the function of the hospital's own auditors, however, and would not involve a review of the hospital's financial controls and internal reporting procedures. But the auditors must review the overall methodology for accumulating data to ensure that the resulting data reflects the required elements. In other words, the independent auditors must review the methodology for arriving at hospital-specific data, and must have confidence that the data accurately represents the hospital's eligible uncompensated care costs consistent with the statutory criteria.

Comment: A few commenters are concerned that the reporting requirements, as stated in the proposed regulation, suggest that there is only one way to calculate DSH payments and hospital-specific DSH payment limits when, in reality, Federal guidelines give States some leeway in making these calculations. The commenters are concerned that auditors will interpret their mandate very literally. One commenter said the State may find itself disagreeing with its auditor over the definitions of certain requirements and methodologies. Without additional CMS clarification, the auditor may revert to a reasonableness test when clarification is lacking, which may not meet the objectives of CMS in promulgating these rules.

Response: We agree that States may have some flexibility in interpreting the payment provisions under their State plan, and we expect that auditors will consult with the State agency on such interpretative issues. The calculation of the hospital-specific limits is less discretionary; DSH payments are limited by Federal law to each qualifying hospital's specific uncompensated care costs incurred in furnishing hospital services to the Medicaid and uninsured populations.

Comment: A few commenters said this rule would adversely affect access to health care for all children, not just Medicaid beneficiaries. Hospitals may be forced to close programs or clinics in order to cover revenue losses and access to care for all children, not just Medicaid beneficiaries would be limited. Children and their families would be forced to seek care in emergency rooms, which is a more expensive visit for Medicaid and will invariably result in ever more crowded emergency rooms.

Response: DSH payments are a way to provide additional funding to hospitals that serve a disproportionate share of low income patients, but the statute limits DSH payments to each hospital to the total uncompensated care costs in serving the Medicaid and uninsured populations. Since these limitations have been in place since 1993, CMS does not believe that any hospital could reasonably have relied on receiving funding above that level. CMS recognizes that States must use estimates to determine DSH payments in a given year. The information available through the reporting and auditing program under this regulation will assist States in ensuring that those estimates do not generate DSH payments that exceed the hospital-specific DSH limit.

Comment: One commenter believes the independent audit requirements should be included in the existing framework for audits of Federal programs under the Single Audit Act and include the five items requiring verification in the OMB Circular A–133 Compliance Supplement. One commenter suggested revision of OMB Circular A–133 Compliance Supplement to require the State Medicaid program's auditor test this reporting requirement by ensuring the Medicaid program received the information and audit assurances from the hospitals, accumulated the information, and properly reported the results to the Centers for Medicare and Medicaid Services.

Response: The DSH audit and report is a necessary element in the administration of the Medicaid program. The purpose of the audit is to ensure that States make DSH payments under their Medicaid program that are in compliance with Section 1923 of the Social Security Act. DSH payments are a small portion of a State's Medicaid program and the OMB Circular A–133 direction is far larger in scope than this audit.

It would be inappropriate to make the requested revisions to OMB Circular A–133 as OMB Circular A–133 specifically exempts Medicaid payments made by the State because these Medicaid payments are not considered to be "federal awards expended under this Section [Section 205, Basis for Determining Federal Awards Expended]". In addition, Subpart E also indicates that the scope of the A–133 Audit shall cover the entire operations of the auditee or a department, agency or other organizational unit.

It should be noted that the Single State Audit Agency qualifies as operating independently from the Medicaid Agency and, therefore, could perform the DSH audit albeit separate from the Single State Audit Act.

Comment: One commenter requests confirmation that the audit would be a Program Performance Audit of the State as defined in Government Auditing Standards, July 1999, Chapter 2, and as such would not require verification by a Certified Public Accounting firm as in the case of financial audits that lead to the expression of an opinion as defined in Chapter 3. One commenter noted that requiring the audits of the States to be performed under Generally Accepted Government Auditing Standards (GAGAS) will ensure that the reports are accurate and can be relied upon by third party users. One commenter stated that there are three sets of standards within GAGAS: Financial Audits, Attestation Engagements, and Performance Audits and questioned which set of standards would apply to the independent audit of DSH payments.

Response: The standards in GAGAS generally exceed the scope and objectives of the DSH audit and report. GAGAS rules govern the audits of government organizations, programs activities, functions or funds. In general, government audits are either performance audits, attestation engagements or financial audits.

In financial and performance audits, the focus is on the government entity, its management of a program and/or the financial management and reporting systems associated with that program. The DSH audit and report is a review of a segment of the Medicaid program and therefore does not fall within the scope of a performance or financial audit under GAGAS rules.

Attestation engagements may take a narrower focus (less than full program review) and, therefore, may seem to more directly fit with the scope of the DSH audit and report. However, attestation agreements under GAGAS rules include standards beyond non-governmental attestation agreements and these additional standards exceed the scope of the DSH audit and report.

The DSH audit and report is a necessary part of the administration of the Medicaid program. The purpose of the audit is to ensure that States make DSH payments under their Medicaid program that are in compliance with Section 1923 of the Social Security Act. The audit does not encompass the review of the State's Medicaid program, it simply ensures that one portion of the program is conducted in compliance with Federal statutory limits. In addition, the DSH audit will rely on financial and cost report data provided by hospitals that are subject to generally accepted accounting principles as part of their primary reporting function.

4. Section 1115 Demonstrations

Comment: One commenter believes the proposed rule as presently drafted will have a significant impact on hospitals if an exemption is not provided. The State has operated its DSH program for a number of years in strict accordance with the prescriptive terms negotiated between the State and CMS.

Response: The MMA imposes audit and reporting requirements on all States that make DSH payments. As part of this process, CMS must determine if all hospitals receiving DSH payments under the Medicaid State plan actually qualify to receive such payments and that actual DSH payments do not exceed

the hospital-specific DHS limit for that same period. To the extent that a State makes DSH payments under a waiver demonstration, the State is not exempted from the rules surrounding DSH payments, particularly those at 1923(g) of the Act, and the audit and reporting requirements would still apply to that State.

Comment: Several commenters had questions regarding how States that operate their Medicaid programs under Federal waivers would do their Medicaid DSH reporting. The commenters suggest the regulation should specify that the DSH reporting and audit requirements do not apply to States that do not make DSH payments or are not required to comply with DSH requirements pursuant to Federal waivers of DSH requirements. The commenters urge CMS to exempt States with 1115 waivers from this rule if the waivers are based on certified public expenditures (CPEs) for Medicaid and DSH payments. One commenter stated that the recent implementation of the State's 1115 waiver completely changes the way DSH payments are calculated for the State's hospitals, therefore, this audit requirement would be duplicative.

Response: These DSH audit and reporting requirements apply to States with Section 1115 demonstrations to the extent that the waiver list associated with the demonstration does not explicitly waive the State from compliance with Section 1923 of the Act. The DSH audit and reporting time frames for States with DSH programs and Section 1115 demonstrations are subject to the same time frames as those States without 1115 demonstrations. The only exception would be if a State has a demonstration project under Section 1115 that includes a waiver of the requirements of Section 1923 so that the State does not make Medicaid DSH payments at all. In that instance, since there are no DSH payments, the DSH audit and reporting requirements would not apply.

5. Time Period Subject to DSH Audit and Report

Comment: One commenter asked for clarification of the treatment of DSH payments when a State makes a portion of the fiscal year's DSH payments after the end of its fiscal year. One commenter asked whether, when DSH payments are made on an accrual accounting basis and adjusted after the report has been filed, whether the State must file a corrected report. Several commenters indicated that dissatisfied hospitals have the ability to appeal their payments, a process that could extend the period of time before the final payment is known. They asked how to report regular Medicaid rate payments that are not known at the end of any given State fiscal year. One commenter said that many States allow Medicaid providers up to a year to submit claims following the date of service. As such, the commenter indicated that there is often a significant lag in payments to Medicaid hospitals and uncompensated care figures would be overstated if only cost incurred and payments received during a SFY are considered.

Response: Since the deadline for reporting the audit findings has been extended to at least three full years after the close of the Medicaid State plan rate year subject to audit, hospitals would have received all Medicaid and DSH payments associated with that Medicaid State plan rate year. This two-year period accommodates the one-year concern expressed in many comments regarding claim lags and is consistent with the varying hospital cost reporting periods and adjustments and accommodates DSH payments made from different allotment years.

It should be noted that, to the extent that a State makes a retroactive adjustment to non-DSH payments after the completion of the audit for that particular Medicaid State plan rate year, the hospital would necessarily have received and booked the revenues in a subsequent Medicaid State plan rate year. Under these circumstances, the revenue adjustments would be measured during the audit of the Medicaid State plan rate year in which the revenues were received.

The treatment of post-audit Medicaid payments, including regular Medicaid rate payments, supplemental and enhanced payments, Medicaid managed care payments, DSH, and "self-pay" revenues and other collections including liens would be treated as revenues applicable to the Medicaid State plan rate year in which they are received.

Comment: Several commenters noted that the State is required to indicate the Medicaid Managed Care Organization Payments paid to the hospital for the SFY being reported. Claims may be submitted to the Medicaid Managed Care Organization (MCO) for payment up to one year after the date of service. Therefore, payments made by the MCO for claims with date of service in the SFY may be submitted up to a year after the service date by the hospital. The payments would not be available before 12 months after the SFY at a minimum. Obtaining the amount paid by the MCO for the SFY being reported is not possible by the end of the SFY.

Response: Based on the modifications to the audit and reporting deadlines and the Medicaid two-year timely filing claim limit, there should not be a significant adjustment to Medicaid payments that would warrant a corrected report. To the extent that such an adjustment to Medicaid payments occurs, no corrected audit or report is necessary. To the extent that a State makes a retroactive adjustment to non-DSH payments after the completion of the audit for that particular Medicaid State plan rate year, the hospital would necessarily have received and booked the revenues in a subsequent Medicaid State plan rate year. Under these circumstances, the revenue adjustments would be measured during the audit of the Medicaid State plan rate year in which the revenues were received.

6. Verification I—Proper Reduction to Uncompensated Care Cost

Comment: Several commenters believe that different parts of the regulation define "uncompensated care costs" differently, and they should be modified and made consistent. The commenters provided suggested changes in an effort to eliminate a contradiction between the definitions, contained in §§ 447.299(c)(15) and 455.204(c). Several commenters believe that Verification #1 requires each hospital receiving DSH payments reduce its uncompensated care costs by the amount of DSH payments received in any given year. The commenters argued that the statute clearly defines the DSH limit so that DSH payments should not be offset against the hospital specific limits. They noted that the language of Section 1923(j) only requires the auditors to verify "'the extent to which" the costs have been reduced. Thus, if costs have not been reduced at all, the auditor would verify that fact and the audit requirement would be met. The regulatory language should be revised to be consistent with the statutory requirement. Other commenters stated that the proposed rule requires an audit verification that each disproportionate share hospital in the State has reduced its uncompensated care costs in order to reflect the total amount of claimed DSH expenditures. They are not clear how a hospital can demonstrate this, as costs generally are not reduced by expenditures. One commenter recognizes that CMS likely based its formulation of the verification requirement on the statutory language, which contains similarly confusing terminology, requiring the audit to verify "the extent to which hospitals in the State have reduced their

uncompensated care costs to reflect the total amount of claimed expenditures made under [the Medicaid DSH statute]." The commenter suggests that a more useful interpretation of this statutory language would be to require verification that DSH payments have not exceeded uncompensated care costs.

Response: The purpose of the statute is for States to audit actual DSH payments made under the approved Medicaid State plan against actual eligible uncompensated hospital costs for the same time period. In reviewing the meaning of the statutory language, we have determined that verification 1 is designed to ensure that hospitals are able to fully retain the DSH payments made to them for the uncompensated cost of providing inpatient and outpatient hospital services to Medicaid beneficiaries and individuals with no source of third party coverage net of all Medicaid payments received and payments by or on behalf of individuals with no source of third party coverage for the services they received. We have revised the regulation text to make this clearer.

7. Verification 2—Calculation of Eligible Uncompensated Care Cost, Prospective Estimates Versus Reconciled Cost

Comment: Many commenters indicated that for States that determine the individual hospital DSH limit prospectively, the one-year filing requirement may be attainable (at least after these rules take effect) if the requirement is only to validate the accuracy of the prospective calculation. But for those States that do base the determination on current year costs, a report based on a final audit of hospital cost reports could not be submitted within one year. Final settlement of hospitals' cost reports is typically contingent upon completion by a Medicare intermediary of audits—a process that can take several years. CMS should allow these States additional time to submit the audit certifications, so these certifications can be based on the final settled cost report. Alternatively, CMS could clarify the rule to permit the required report to be based on a hospital's as-filed cost report. If necessary, there could be later reconciling adjustment after the cost report is finally settled and an audit certification can be made.

Response: CMS recognizes that States may need to use estimates to determine DSH payments made by States to individual qualifying hospitals in an upcoming Medicaid State plan rate year. Section 1923(j) of the Act requires States to report and audit hospital-specific DSH payments and hospital-specific uncompensated care costs. To meet this requirement, States must perform audits associated with defined periods of time and must identify the actual costs incurred and payments received during that defined time period. To respond to comments on the practicality of audit timing, we have modified the time frame for the audit and reporting requirements as discussed above. We also note that we expect that reports and audits will be based on the best available information. If audited Medicare cost reports are not available, the DSH report and audit may need to be based on Medicare cost reports as filed.

Comment: Numerous States indicated that if the audit requirement is simply to verify the manner in which the DSH limit was applied prospectively, the one-year timeline may be realistic for years subsequent to the adoption of a final regulation for States using prospective methods, and hospitals with fiscal years different than the State's should not present as much of a concern, because the prospectively determined limit would have been calculated based on cost reports for earlier time periods. Accordingly, the commenters request that CMS clarify that the proposed regulations are not intended to disturb the use of prospective calculations to apply the individual hospital DSH limit.

Response: This regulation is not intended to require States to implement retrospective DSH methodologies. CMS recognizes that States may need to use estimates to determine DSH payments in an upcoming Medicaid State plan rate year. However, Section 1923(j) of the Act requires confirmation that DSH payments made by States to individual qualifying hospitals do not exceed the actual cost limitation imposed by Congress.

Based on the revisions to the auditing and reporting timeframes, which, in part, requires the Medicaid State Plan rate year 2005 and 2006 audits to be completed no later than the last day of Federal fiscal year 2009, it is feasible for the audit to measure eligible uncompensated care costs incurred against the DSH payments received in a given time frame. The transition period included in the final regulation ensures that States may adjust those estimates prospectively to avoid any immediate adverse fiscal impact and to ensure that future DSH payments do not exceed the hospital-specific DSH limits.

Comment: Several commenters noted that there is no current law requiring that DSH payments made in a fiscal year correspond to costs from that same fiscal year. In addition, CMS has never before imposed a reconciliation requirement. A few commenters stated Section 1923(g) of the Act does not require that the OBRA 1993 limits be recalculated and reapplied to reflect subsequently available year-of-service data.

Response: Section 1923(j) of the Act requires States to report and audit specific payments and specific costs. These reports must assess compliance with the statutory hospital-specific limitations on the level of DSH payments to which qualifying hospitals were entitled. Section 1923(g)(1)(A) specifies that DSH payments cannot exceed, "the costs incurred during the year of furnishing hospital services (as determined by the Secretary and net of payments under this title, other than under this Section, and by uninsured patients * * *)". The goal of the regulation is to audit DSH payments made under the authority of the Medicaid State plan and to ensure that States do not make DSH payments that exceed the hospital-specific cost limit defined under the Omnibus Budget Reconciliation Act of 1993.

CMS recognizes that States may need to use estimates to determine DSH payments in an upcoming Medicaid State plan rate year. However, the statute requires confirmation that DSH payments do not exceed the actual cost limitation imposed by Congress.

Comment: Numerous commenters stated that the DSH reporting and auditing requirements contained in MMA were intended only to ensure compliance with the DSH requirements, not to change the DSH requirements themselves. They asserted that nothing in the statute either requires or encourages a change in CMS's longstanding policy that DSH payments can be based on a prospective estimate of a hospital's uncompensated care costs. They argued that the statute does not require that payments be based on actual audited costs and nothing in the statute requires CMS to impose this dramatic shift in policy. This approach allows for adjustment during future years for reconciling DSH payments to actual costs. Numerous commenters said that CMS has always acknowledged that the law permits States to base their DSH payments on a prospective estimate of a hospital's uncompensated care costs for a given year, derived from the hospital's costs in prior years, and many if not most States utilize this approach. A few commenters noted that CMS has allowed States flexibility to use estimates of current year uncompensated costs. One commenter stated the statute provides that a DSH payment adjustment "during a fiscal

year" is considered non-compliant with the limit if the adjustment exceeds the uncompensated costs for Medicaid and uninsured patients incurred "during the year" and that CMS appears to be basing this burdensome reconciliation requirement solely on this language. The commenter believes that while the provision does limit current year payments to current year costs, nothing in the language mandates the use of actual audited costs. Indeed, the commenter indicated that reliable estimates based on audited prior year data will produce sufficient controls on the DSH payments and fulfill Congress' intent of limiting DSH expenditures on a hospital-specific basis.

Response: Section 1923(g)(1)(A) of the Act specifies that DSH payments cannot exceed, "the costs incurred during the year of furnishing hospital services (as determined by the Secretary and net of payments under this title, other than under this Section, and by uninsured patients * * *)". The goal of the regulation is to audit DSH payments made under the authority of the Medicaid State plan and to ensure that States do not make DSH payments that exceed the hospital-specific cost limit defined under the Omnibus Budget Reconciliation Act of 1993.

Section 1923(j) of the Act expressly requires States to report and audit specific payments and specific costs. As part of this process, CMS must obtain all information necessary to determine if all hospitals receiving DSH payments under the authority of the approved Medicaid State plan actually qualify to receive such payments and that actual DSH payments made by States do not exceed the hospital-specific limit for the same period. DSH payments are limited by Federal law to each qualifying hospital's specific eligible uncompensated care cost limit.

CMS recognizes that States may need to use estimates to determine DSH payments in an upcoming Medicaid State plan rate year. However, the statute requires confirmation that DSH payments do not exceed the actual cost limitation imposed by Congress. CMS has modified the regulation to include a transition period to ensure that States may adjust those estimates prospectively to avoid any immediate adverse fiscal impact and to ensure that future DSH payments do not exceed the hospital-specific DSH limits.

Auditing actual payments made in a given year against estimated hospital uncompensated care costs in that same year would not ensure that DSH payments did not exceed actual uncompensated care costs. Several Inspector General audits attest to the discrepancies in the results. In fact, measuring the difference between DSH payments and estimates of uncompensated care costs would never produce a true determination of whether or not DSH payments in a given year exceeded the Congressionally defined cost limit for that year.

Comment: Numerous commenters indicated that States cannot determine the actual uncompensated care costs prior to or during the year that DSH payments are made. The commenters stated that this could prevent States from making prospective estimates of Medicaid shortfalls and uninsured costs. The commenters recommend that States be allowed to continue to utilize historical information to perform prospective DSH limit calculations.

Response: CMS recognizes that States may need to use estimates to determine DSH payments in an upcoming Medicaid State plan rate year. However, CMS does not have authority to authorize payments that exceed statutory hospital-specific limits and those limits are based on actual uncompensated care costs. The goal of the regulation is to audit DSH payments made under the authority of the Medicaid State plan and to ensure that States do not make DSH payments that exceed those statutory hospital-specific cost limits. The information necessary for such confirmation is readily available to hospitals and the State based on existing financial and cost reporting tools.

Comment: Many commenters noted that the proposed methodology would be inconsistent with their approved Medicaid State plan and conflicts with past CMS guidance and practice. They indicate that a retrospective audit to determine the accuracy of the estimates used to determine uncompensated care costs based on the approved prospective methodology would require changing the State plan. They ask how this audit should be conducted by States that already have CMS approval for use of prospective methodologies, not to mention that a retroactive audit could significantly affect already approved programs.

Response: This regulation is not intended to require States to implement retrospective DSH methodologies. CMS recognizes that States may need to use estimates to determine DSH payments in an upcoming Medicaid State plan rate year. However, CMS cannot authorize DSH payments that exceed the limitations imposed by Congress. States will have to determine how to best ensure that prospective DSH methodologies do not result in payments that exceed those limitations, either by revising those methodologies or by providing for reconciliation of prospective payments with those limits. CMS as always is available to offer technical assistance to States in developing such methodologies.

CMS has modified the regulation to include a transition period to ensure that States may adjust prospective estimates to avoid any immediate adverse fiscal impact.

8. Fiscal Impact—Effect on Federal Financial Participation

Comment: A few commenters questioned whether CMS will withhold Federal Financial Participation from the States until its Independent Audit of DSH Payments is completed and filed with CMS.

Response: The final regulation defines the time periods applicable to the auditing and reporting of DSH payments. These deadlines provide sufficient time for States to comply with the statute. The final regulation also provides that Federal financial participation for DSH payments is not available to any State that has not submitted its required audits and reports.

Comment: A few commenters said that the proposed regulation states the penalty for failure to provide the required information by the stipulated deadline but does not address the question of whether or not CMS will require States to return DSH funds if the information collected is unsatisfactory to CMS.

Response: The goal of the regulation is to audit DSH payments made under the authority of the Medicaid State plan and to ensure that States do not make DSH payments that exceed the hospital-specific cost limit defined in Section 1923(g) of the Act. CMS has modified the regulation to include a transition period to ensure that States have an opportunity to refine audit and reporting practices and determine the impact on the State DSH methodologies. The final regulation provides that Federal financial participation for DSH payments is not available to any State that has not submitted its required audits and reports. However, CMS intends to work with States to ensure that the audits and reports meet all statutory and regulatory requirements.

Comment: A few commenters asked for clarification on the actions that may be taken against States if States are not found to be in compliance with all verifications required as part of the audit (§ 455.204(c)).

Response: The final regulation defines the time periods applicable to the auditing and reporting of DSH

payments. These deadlines provide sufficient time for States to comply with the statute. The final regulation also provides that Federal financial participation in DSH payments is not available to any State that has not submitted its required audits and reports. As mentioned above, CMS intends to work with States to ensure that the audits and reports meet all statutory and regulatory requirements.

Comment: A few commenters said the proposed regulation is silent on the question of post-audit adjustments. In some cases, audits will reveal actual costs that were not included in the estimated uncompensated care costs provided. In such cases, provided there are funds remaining in the State's DSH allotment or other money available for such purposes, the commenters recommended that States should be permitted to compensate hospitals.

Response: CMS has modified the regulation to lengthen the time frame for preparation of the required report and audit, and to include a transition period to ensure that States have time to refine their audit processes. The instance of post audit adjustments will be significantly lessened as a result.

9. Verification Three—Data Sources Used in Calculation of Eligible Uncompensated Care Costs

Comment: Many commenters requested clarity on the mechanics of reconciliation. Although the MMA requires an annual certified public audit, the proposed rule is unclear about how the audit will reconcile DSH payments and the hospitals' calculation of actual compensated care. Hospitals submit accurate data on Medicaid and uncompensated care at a point in time. Data can change over time as claims and payment appeals are settled.

Response: We believe that the three-year period allotted for completion of the audit accommodates these concerns. Sufficient time is available to ensure that necessary cost reports and other financial data are available to make these determinations. This accommodates the concern expressed in many comments regarding claims lags and is consistent with the varying hospital cost report periods and adjustments. CMS has developed a General DSH Audit and Reporting Protocol to provide guidance to States, DSH hospitals and auditors in the completion of the DSH audit. This protocol provides general instructions regarding the calculations the auditor will make based on the data provided.

10. Verification Four—Proper Accounting of Medicaid and Uninsured Revenues

Comment: A few commenters noted that the audit and reporting requirements are unnecessary in several States where the federal DSH allocation to the States has consistently fallen short of the State's aggregate DSH limit by at least $200 million in each of the past five years.

Response: The Statewide aggregate DSH allotment is only one of the limitations on DSH payments. The audit and reporting requirements also concern hospital-specific limitations, which involve review of specific payments and specific costs by individual hospital. The goal of the audit and report is to ensure that DSH payments made by States under the authority of the approved Medicaid State plan do not exceed the hospital-specific uncompensated care cost limit as required by Section 1923(g) of the Act. Irrespective of a State's aggregate DSH allotment, or overall levels of uncompensated care, a DSH hospital may not receive more in DSH payments than the individual hospital's eligible uncompensated care costs.

Comment: A few commenters stated that the financial exposure for the Federal government through the use of estimated rather than reconciled data is not significant, as total DSH expenditures are limited by the Statewide DSH allotment. The benefit obtained through the reconciliation mandate is therefore far outweighed by its costs.

Response: As discussed above, the Statewide DSH allotment and hospital-specific limitations are separate and distinct. Section 1923(g)(1)(A) of the Act specifies that DSH payments cannot exceed, "the costs incurred during the year of furnishing hospital services (as determined by the Secretary and net of payments under this title, other than under this Section, and by uninsured patients * * *)". Section 1923(j) of the Act and this regulation require States to audit DSH payments made under the authority of the Medicaid State plan and to ensure that States do not make DSH payments that exceed this hospital-specific cost limit.

The data elements necessary for the State to complete the DSH audit and report should, in part, be information the State already gathers to administer the DSH program. Thus, CMS believes that the burden on the State will not be substantial. The State will have some additional cost associated with engaging an auditor but that cost is eligible for Federal administrative matching funds.

Comment: Numerous commenters expressed concern about the proposed rule because adoption would greatly reduce the DSH payments to hospitals. Such a reduction would eliminate some of the future services hospitals provide. The largest burden would be on the impoverished communities since many of those people could not travel to receive those services elsewhere.

Response: Hospitals should not realize a significant reduction in DSH payments based on the audit and reporting requirements. Moreover, any reduction would simply be the result of ensuring that limited State DSH funds are used appropriately and meet the requirements of the Medicaid statute. This rule will help to ensure that Medicaid DSH payments appropriately recognize allowable unreimbursed Medicaid and uninsured uncompensated care costs. The DSH law was enacted to recognize needs of hospitals that serve a disproportionate number of Medicaid and low-income patients. In 1993, Congress imposed hospital-specific limitations on the level of DSH payments to which qualifying hospitals were entitled. Section 1923(g)(1)(A) specifies that DSH payments cannot exceed, "the costs incurred during the year of furnishing hospital services (as determined by the Secretary and net of payments under this title, other than under this Section, and by uninsured patients * * *)". Congress clearly identified the DSH limit as specific to the costs incurred for providing certain hospital services to Medicaid individuals and individuals with no source of third party coverage.

Comment: Several commenters expressed concern that the results of audits may be used to attempt to take back money from States and/or hospitals for failing to meet standards that they never knew existed, long after hospital's fiscal year is over. If the State would be required to return DSH money to the Federal Government, this would necessitate the return of DSH money to the State by hospitals. This would be extremely burdensome for hospitals, which undoubtedly would already have spent that money serving their low-income and uninsured patients. One commenter said that after-the-fact exposure is untenable for States with balanced budget requirements.

Response: CMS has modified the regulation to include a transition period to ensure that States may adjust uncompensated care estimates prospectively to avoid any immediate adverse fiscal impact and to assist States in ensuring that future DSH payments do not exceed the hospital-specific DSH limit. To permit States an opportunity to

develop and refine audit procedures, audit findings from Medicaid State plan rate year 2005–2010 will be limited to use for the purpose of estimating prospective hospital-specific uncompensated care cost limits in order to make actual DSH payments in the upcoming Medicaid State plan rate years. CMS is not requiring retroactive collection for Medicaid State plan rate years that have already passed. By using that time to improve State DSH payment methodologies, States may avoid circumstances in which DSH payments that exceed Federal statutory limits must be recouped from hospitals. CMS will also be available to provide necessary technical assistance to States to ensure proper implementation of these requirements.

Comment: One commenter said that their State plan permitted DSH payments to DSH-eligible, out-of-State hospitals that service the State's Medicaid recipients. The commenter requested clarity regarding the State's responsibility in terms of hospital-specific DSH limit calculations and auditing and reporting requirements insofar as these out-of-State hospitals are concerned.

Response: A State is required to audit payments and costs for only those DSH hospitals that are located within the State. This method will allow the auditor to recognize DSH payments received from other States in addition to the DSH payments received by that hospital under the "home-State's" approved Medicaid State plan.

For States that make DSH payments to hospitals in other States, the State must include in the reporting requirements the DSH payments made to hospitals located outside of the State but would not be required to audit those out-of-State DSH hospital's total DSH payments/total eligible uncompensated care costs. This method will ensure that no DSH hospital is audited more than one time per year for purposes of the DSH auditing and reporting requirements under Section 1923(j) of the Act.

Comment: A few commenters asked whether CMS will require States to include in the report information on patients from another State.

Response: The goal of the audit and report is to ensure that DSH payments made by States under the authority of the approved Medicaid State plan do not exceed the hospital-specific cost limit. In order to do this, all applicable revenues must be offset against all eligible costs. For purposes of determining the hospital-specific DSH limit, revenues would include all Medicaid payments made to hospitals for providing inpatient and outpatient hospital services to Medicaid individuals (irrespective of the State in which the individual is eligible) and all payments made by or on behalf of patients with no source of third party coverage for the inpatient and outpatient hospital services they received. For purposes of the DSH audit and to determine whether hospital-specific cost limits have been exceeded, all DSH payments made by States and received by a hospital would need to be offset against the determined eligible uncompensated care cost limit.

Any Medicaid payments received by a hospital from any Medicaid agency (in state or out of state) should be counted as revenue offsets against total incurred Medicaid costs. Any DSH payments received by a hospital from any Medicaid agency (in state or out of state) must be counted as an offset against uncompensated care for purposes of the DSH audit and ensuring that the hospital-specific DSH limit is not exceeded.

Comment: One commenter requested instructions for reporting information to CMS related to DSH payments on an annual basis. Annual reporting requirements also contain specific reporting requirements related to DSH payments. The commenter asked for clarification as to whether the proposed rules supersede the reporting requirements detailed in the March 26, 2004, **Federal Register** Notice [CMS–2062–N].

Response: All DSH reporting requirements published under CMS–2062–N are superseded by Section 1923(j) of the Act and this implementing regulation.

Comment: A few commenters noted the proposed § 447.299(c)(8) incorrectly refers to Section 1923(g) instead of referring to the entire Section 1923.

Response: The regulation has been modified to reflect the correct statutory citation.

Comment: A few commenters noted that the Reporting form was not included with the proposed rules and requested a copy of the example Reporting form.

Response: A modified Reporting form is included in this regulation.

Comment: One commenter noted that in FY 2003, total Federal DSH allotments to States totaled just under $9 billion. The commenter requests copies of any audit findings and/or programs associated with CMS' historic and ongoing efforts to audit and/or verify the figures used by States to justify Federal funds.

Response: The commenter may request information consistent with the authority of the Freedom of Information Act.

Comment: One commenter noted CMS has not pointed to any systematic findings that call into question the reasonableness of approved methodologies.

Response: The statutory authority under MMA instructed States to report and audit specific payments and specific costs. This rule does not call into question the reasonableness of approved methodologies; it simply implements the statutory reporting and auditing requirements to determine whether DSH payments were proper with respect to the specific DSH hospitals that were paid.

C. Regulatory Impact

Comment: Several commenters stated that there would be a significant burden on the States for the reporting requirement in terms of time and effort to prepare and submit the required information and that CMS' estimate of the time needed for the proposed § 447.299(c) reporting requirements is underestimated. One commenter questioned whether this estimate is based upon an assumption by CMS that States have historically been collecting and verifying the information required in the report to CMS. The commenter requested that CMS provide details on how this estimate was calculated.

Response: CMS believes that since the audit relies on documents already available to hospitals that the audit data burden will neither be significant nor costly. The reporting of each year's audit findings will be achieved through the completion of a one-page Reporting form. The elements necessary for this report will be extrapolated from the data and analysis performed by the auditor and will be based on existing source documentation.

Comment: One commenter noted that if a State utilizes different criteria for qualifying hospitals as a DSH than the Medicaid Inpatient Utilization Rate or the Low-Income Utilization Rate, then these two calculations would be unnecessary. The commenter asserted that requiring a State to calculate and submit the Medicaid Inpatient Utilization Rate and Low-Income Utilization Rate calculations would be an additional burden. The commenter asked if CMS considered this added effort in the estimate of States' time and effort to prepare and submit the required information.

Response: Section 1923(j) of the Act imposes audit and reporting requirements on States regarding payments to DSH eligible hospitals. As part of this process, CMS must

determine if all hospitals receiving DSH payments under the Medicaid State plan actually qualify to receive such payments. Sections 1923(b)(1)(A) and (B) of the Act require that all hospitals meeting the Medicaid Inpatient Utilization Rate (MIUR) or the Low Income Utilization Rate (LIUR) calculated therein are deemed DSH hospitals. This is the minimum Federal standard. States have the right to use alternative qualifying criteria that are broader. States that use only the LIUR or only the MIUR to determine DSH qualification should report on the statistic utilized in the approved Medicaid State plan for the Medicaid State plan rate year under audit. State using a broader methodology should use that statistic in lieu of the MIUR or LIUR.

We believe that since the audit relies on documents already available to hospitals that the audit data burden will neither be significant nor costly. The reporting of each year's audit findings will be achieved through the completion of a one page Reporting form. The elements necessary for this report will be extrapolated from the data and analysis performed by the auditor and will be based on existing source documentation.

Comment: A few commenters believe that the information collection burden is significant, that in many cases the information requested is ambiguous or inaccurate and there are likely more efficacious means of implementing the statutory requirements, for instance, by more closely tracking the S–10 categories. The commenters urge CMS to revise the regulation to reduce the paperwork burden associated with the new audit and reporting requirements and avoid imposing unnecessary additional administrative costs on States and hospital providers by considering less burdensome means of collecting necessary information.

Response: Hospitals will be required to provide the State with data extracted from existing cost and financial reporting tools as well as copies of the source documents. The State must provide these data as well as Medicaid Management Information Systems and Medicaid State plan information to the auditor. The source documents would include the Medicare 2552–96 cost report, audited hospital financial statements and hospital accounting records in combination with information provided by the State's MMIS.

We believe that since the audit relies on documents already available to hospitals that the audit data burden will neither be significant nor costly. The reporting of each year's audit findings will be achieved through the completion of a one page Reporting form. The elements necessary for this report will be extrapolated from the data and analysis performed by the auditor and will be based on existing source documentation.

Worksheet S–10 is not part of the Medicare 2552–96 step-down process used to allocate inpatient and hospital outpatient costs. The cost allocation process utilized in the Medicare 2552–96 cost report is considered a key component of determining Medicaid and uninsured hospital costs.

Comment: One commenter said that while collection activities in response to audit requirements are exempt from the Paperwork Reduction Act, CMS should acknowledge that the new substantive requirements that it is announcing in the form of audit standards will impose independent new paperwork burdens on States separate and apart from the response to the audits. For example, CMS' proposal that the audits verify that DSH payments do not exceed actual year costs will impose a massive new DSH reconciliation requirement on States so that the audits do not conclude that they have exceeded the hospital-specific DSH limits. Therefore, the commenters believe CMS should evaluate the paperwork burden associated with new standards announced as part of the audit requirements as well as the reporting requirements.

Response: The goal of the regulation is to audit DSH payments made under the authority of the Medicaid State plan and to ensure that States do not make DSH payments that exceed the hospital-specific cost limit defined under Section 1923(g) of the Act. The information necessary for such confirmation is readily available to hospitals and the State based on existing financial and cost reporting tools. The reporting of each year's audit findings will be achieved through the completion of a one page Reporting form. The elements necessary for this report will be based on existing source documentation.

Comment: Several commenters noted that the proposed rules will have a significant economic impact and therefore, the Regulatory Flexibility Act (RFA) requires CMS to analyze options for regulatory relief of small businesses, such as hospitals. The newly announced DSH requirements contained in the proposed rule and discussed throughout this comment letter may result in decreased DSH funding for some hospitals, jeopardizing their ability to provide broad access to services for the uninsured and underinsured.

Response: CMS believes that this rule would not have a significant economic impact on a substantial number of small entities. The regulation requires States to audit and report DSH payments made to DSH eligible hospitals in a given Medicaid State plan rate year. Hospitals will only be required to provide data to States from existing primary source documents such as the Medicare 2552–96 cost report, audited hospital financials, and hospital accounting records. The regulation also includes a transition period to ensure that no immediate fiscal impact is realized by States or hospitals.

Comment: Many commenters noted that the cost for hospital audits can reach $50,000 or higher per hospital and therefore contended that the estimate clearly suggests the economic impact of this one audit requirement will meet the test of a major rule under the Regulatory Flexibility Act.

Response: Although the State will have some additional cost associated with engaging an auditor, but that cost is eligible for Federal administrative matching funds. The DSH audit and report is a necessary element in the administration of the Medicaid program to ensure that hospital-specific DSH limits are not exceeded by DSH payments made under the approved Medicaid State plan for a given year.

Hospitals should not incur additional costs as they will be required to provide the State with data extracted from existing hospital cost and financial reporting tools supplemented with State generated data from the State's Medicaid Management Information System.

IV. Changes to the Proposed Rule

As explained in our responses to comments, we have made the following revisions to the DSH Auditing and Reporting regulations published in the August 26, 2005 Proposed Rule:

A. Reporting Requirements

1. Audit Year and Submission Dates Defined

CMS has modified the regulation at § 447.299(c) to address concerns regarding the inability to complete the audit and report within a year from the end of SFY 2005. The regulation has been modified to identify the Medicaid State plan rate year 2005 as the first time period subject to the audit. The basis for this modification is recognition of varying fiscal periods between hospitals and States. The Medicaid State plan rate year is the one uniform time period under which all States must estimate uncompensated costs in order

to make DSH payments under the approved Medicaid State plan. The regulation has also been modified to identify that each audit report must be submitted to CMS within 90 days of the completion of the independent certified audit. The reports associated with Medicaid State plan rate years 2005 and 2006 are due no later than December 31, 2009. Each subsequent audit report is due no later than December 31st of the FFY ending three years after the Medicaid State plan rate year under audit.

2. Report Data Elements

CMS has modified the regulation at § 447.299(c) to address many comments concerning the necessary data elements to fulfill the audit and reporting requirements. Specifically, the regulation has been modified to remove the following data elements:

1. Medicare provider number.
2. Medicaid provider number.
3. Type of hospital.
4. Type of hospital ownership.
5. Transfers.
6. Medicaid eligible and uninsured individuals.

In addition, the regulation at § 447.299(c) has been modified to add or clarify the following data elements which are necessary to fulfill the auditing and reporting requirements:

1. Identification of facilities that are Institutes for Mental Disease (IMD) receiving DSH payments;
2. Identification of out-of-state hospitals receiving DSH payments;
3. State estimate of hospital-specific DSH limit;
4. Medicaid inpatient utilization rate (if applicable);
5. Low-income utilization rate (if applicable);
6. State-defined DSH eligibility statistic (if applicable);
7. Total inpatient and outpatient Medicaid payments;
8. Total inpatient and outpatient Medicaid cost of care;
9. Total Medicaid inpatient and outpatient uncompensated care;
10. Total inpatient and outpatient uninsured and self-pay revenues;
11. Total applicable Section 1011 payments received by the hospital;
12. Total inpatient and outpatient uninsured cost of care;
13. Total inpatient and outpatient uninsured uncompensated care;
14. Total eligible inpatient and outpatient uncompensated care.

The Reporting form has also been modified to reflect these modifications.

B. Audit Requirements

1. Definitions

CMS has modified the regulation at § 455.201 to clarify the definition of independent certified audit to mean that the Single State Audit Agency or any other CPE firm that operates independently from the Medicaid agency is eligible to perform the DSH audit and to define Medicaid State plan rate year as the time period subject to the audit. The definition of State fiscal year has been removed.

2. Certified Independent Audit Requirements

Based on many comments regarding the potential immediate adverse fiscal impact of the DSH audit on States, CMS has modified the regulation at § 455.204(a) to indicate conditions related to the audit that States must meet in order to receive Federal disproportionate share hospital payments. A transition period related to audit findings for Medicaid State plan rate year 2005 through 2010 is included in this Section. Instructions regarding audit findings and their applicability to Medicaid State plan rate year 2011 forward are also included. The modifications are as follows:

- Transition period. Findings of the 2005 and 2006 Medicaid State plan rate year audit and report will be available to States during their SFY 2010. These findings must be taken into consideration for Medicaid State plan rate year 2011 uncompensated care cost estimates and associated DSH payments.
- Audit findings associated with Medicaid State plan rate years 2007 through 2010 must be similarly considered for Medicaid State plan rate years 2012 through 2015. Findings from Medicaid State plan rate year 2005–2010 will be used only for the purpose of determining prospective hospital-specific eligible uncompensated care cost limits and associated DSH payments.
- DSH payments that exceed the hospital-specific eligible uncompensated care cost limit related to Medicaid State plan rate year 2011 must be returned to the Federal government or redistributed by States to other qualifying hospitals.

In response to many public comments regarding the inability of States to complete the audit within one year of the end of the State fiscal year, CMS has modified the regulation at § 455.204(b) to indicate a new time period for the submission of the independent certified audit. The new time period is as follows:

- Identify that the Medicaid State plan rate year 2005 and 2006 audits must be completed no later than the last day of Federal fiscal year 2009. Each subsequent audit beginning with Medicaid State plan rate year 2007 must be completed by the last day of the Federal fiscal year ending three years from the Medicaid State plan rate year under audit. Therefore, for the 2007 Medicaid State plan rate year, the audit must be completed by the last day of Federal fiscal year 2010.

The regulation was modified at 455.204(c) to include a new Section identifying the primary sources and source documents from which States will draw data necessary to complete the independent certified audit. These documents are identified as:

- The approved Medicaid State plan for the State plan rate year under audit.
- State Medicaid Management Information System payment and utilization data.
- The Medicare 2552–96 cost report or subsequent Medicare defined hospital cost report tool.
- DSH hospital audited financial statements and hospital accounting records.

The regulation was modified to redesignate § 455.204(c) as § 455.204(d)(1) through (6) to accommodate the new § 455.204(c).

In addition, CMS developed a General DSH Auditing and Reporting Protocol to provide States with guidance on the completion of the DSH Audit and Report. This protocol will be available on the CMS Web site.

V. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 30-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, Section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

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

Therefore, we are soliciting public comment on each of these issues for the following information collection requirements discussed below.

Section 447.299 Reporting Requirements

Paragraph (c) of this Section requires the States to submit to CMS information for each DSH for the most recently-completed fiscal year beginning with the first full State fiscal year (SFY) after the enactment of Section 1001(d) of the MMA, which for all States will begin with their respective SFY 2005 and each subsequent SFY. This paragraph presents the information to be submitted.

The burden associated with this requirement is the time and effort for the States to prepare and submit the required information. We estimate that it will take each State approximately 30 minutes to prepare and submit the information for each of its DSHs. On average, each State has approximately 75 DSHs. Therefore, we estimate it will take 38 hours per State to comply for a total of 1,976 annual hours. The burden for this requirement is currently approved under OMB # 0938–0746 with an expiration date of August 31, 2011.

Section 455.204 Condition for Federal Financial Participation

In summary, this Section states what information must be included in the audit report and submitted to CMS.

The PRA exempts the information collection activities referenced in this Section. In particular, 5 CFR 1320.4 excludes collection activities during the conduct of administrative actions, investigations, or audits involving an agency against specific individuals or entities.

As required by Section 3504(h) of the Paperwork Reduction Act of 1995, we have submitted a copy of this final regulation to OMB for its review of these information collection requirements described above.

If you comment on these information collection and recordkeeping requirements, please mail copies directly to the following:

Centers for Medicare & Medicaid Services, Office of Strategic Operations and Regulatory Affairs, Division of Regulations Development, Attn.: Melissa Musotto, CMS–2198–F, Room C5–14–03, 7500 Security Boulevard, Baltimore, MD 21244–1850.

Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503, Attn.: Katherine T. Astrich, CMS Desk Officer, CMS–2198–F, *Katherine_T._Astrich@omb.eop.gov*. Fax (202) 395–6974.

VI. Regulatory Impact Analysis

We have examined the impact of this rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), Section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), and Executive Order 13132 on Federalism, and the Congressional Review Act (5 U.S.C. 804(2)).

Executive Order 12866, as amended, directs agencies to asses 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 businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations and government agencies. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $7 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 the Secretary has determined and we certify that this rule would not have a significant economic impact on a substantial number of small entities. This rule will directly affect States.

In addition, Section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of Section 604 of the RFA. For purposes of Section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a metropolitan statistical area and has fewer than 100 beds. Therefore, the Secretary has determined and we certify that this final rule will not have a significant impact on the operations of a substantial number of small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act (UMRA) 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 2008 that threshold level is approximately $130 million. Since this rule would not mandate spending on State, local, or tribal governments in the aggregate, or by the private sector of $130 million or more in any 1 year, the requirements of the UMRA are not applicable.

Based upon the parameters of this rule and comments received, we do not believe the costs incurred by States will be significant. The final rule allows the DSH audits to be part of a hospital's annual financial audit (for example, the auditors would follow the DSH limit protocol provided in the regulation), which means a portion of the audit costs could actually be borne by the hospitals and not the States. Based upon comments received, it appears that most States want to incorporate the DSH audit into the annual hospital financial audits. If that is the case, the costs to the hospital should be minimal as well since the annual hospital financial audit is already a requirement.

It is further unknown if any States will contract with an independent accounting firm to conduct the audit. While there would be a contracting cost to the State, it is unknown what that cost would be and we believe it unlikely that States will avail themselves of this option. The final rule does allow for the use of the Single State Auditor to perform the DSH audit and if that is done, CMS would match the State audit costs at the 50 percent administrative matching rate.

Regardless of the mechanism for conducting the DSH audit, the auditor will be using existing documentation (for example, hospital cost reports, hospital accounting records, and MMIS) and apply the methodology provided by this rule, which should result in nominal costs.

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 of State and local governments, preempts State law, or otherwise has Federalism implications. Since this rule would not impose any costs on State or local governments, preempt State law, or otherwise have Federalism implications, the requirements of E.O. 13132 are not applicable.

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

List of Subjects

42 CFR Part 447

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

42 CFR Part 455

Fraud, Grant programs—health, Health facilities, Health professions, Investigations, Medicaid, and Reporting and recordkeeping requirements.

■ The Centers for Medicare & Medicaid Services amends 42 CFR chapter IV as follows:

PART 447—PAYMENTS FOR SERVICES

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

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

■ 2. Section 447.299 is amended by—
■ A. Redesignating existing paragraphs (c) and (d) as paragraphs (d) and (e).
■ B. Adding a new paragraph (c) to read as set forth below.

§ 447.299 Reporting requirements.

* * * * *

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

(1) *Hospital name.* The name of the hospital that received a DSH payment from the State, identifying facilities that are institutes for mental disease (IMDs) and facilities that are located out-of-state.

(2) *Estimate of hospital-specific DSH limit.* The State's estimate of eligible uncompensated care for the hospital receiving a DSH payment for the year under audit based on the State's methodology for determining such limit.

(3) *Medicaid inpatient utilization rate.* The hospital's Medicaid inpatient utilization rate, as defined in Section 1923(b)(2) of the Act, if the State does not use alternative qualification criteria described in paragraph (c)(5) of this section.

(4) *Low income utilization rate.* The hospital's low income utilization rate, as defined in Section 1923(b)(3) of the Act if the State does not use alternative qualification criteria described in paragraph (c)(5) of this section.

(5) *State defined DSH qualification criteria.* If the State uses an alternate broader DSH qualification methodology as authorized in Section 1923(b)(4) of the Act, the value of the statistic and the methodology used to determine that statistic.

(6) *IP/OP Medicaid fee-for-service (FFS) basic rate payments.* The total annual amount paid to the hospital under the State plan, including Medicaid FFS rate adjustments, but not including DSH payments or supplemental/enhanced Medicaid payments, for inpatient and outpatient services furnished to Medicaid eligible individuals.

(7) *IP/OP Medicaid managed care organization payments.* The total annual amount paid to the hospital by Medicaid managed care organizations for inpatient hospital and outpatient hospital services furnished to Medicaid eligible individuals.

(8) *Supplemental/enhanced Medicaid IP/OP payments.* Indicate the total annual amount of supplemental/enhanced Medicaid payments made to the hospital under the State plan. These amounts do not include DSH payments, regular Medicaid FFS rate payments, and Medicaid managed care organization payments.

(9) *Total Medicaid IP/OP Payments.* Provide the total sum of items identified in § 447.299(c)(6), (7) and (8).

(10) *Total Cost of Care for Medicaid IP/OP Services.* The total annual costs incurred by each hospital for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individuals.

(11) *Total Medicaid Uncompensated Care.* The total amount of uncompensated care attributable to Medicaid inpatient and outpatient services. The amount should be the result of subtracting the amount identified in § 447.299(c)(9) from the amount identified in § 447.299(c)(10). The uncompensated care costs of providing Medicaid physician services cannot be included in this amount.

(12) *Uninsured IP/OP revenue.* Total annual payments received by the hospital by or on behalf of individuals with no source of third party coverage for inpatient and outpatient hospital services they receive. This amount does not include payments made by a State or units of local government, for services furnished to indigent patients.

(13) *Total Applicable Section 1011 Payments.* Federal Section 1011 payments for uncompensated inpatient and outpatient hospital services provided to Section 1011 eligible aliens with no source of third party coverage for the inpatient and outpatient hospital services they receive.

(14) *Total cost of IP/OP care for the uninsured.* Indicate the total costs incurred for furnishing inpatient hospital and outpatient hospital services to individuals with no source of third party coverage for the hospital services they receive.

(15) *Total uninsured IP/OP uncompensated care costs.* Total annual amount of uncompensated IP/OP care for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individuals and to individuals with no source of third party coverage for the hospital services they receive. The amount should be the result of subtracting paragraphs (c)(12) and (c)(13), from paragraph (c)(14) of this section. The uncompensated care costs of providing physician services to the uninsured cannot be included in this amount. The uninsured uncompensated amount also cannot include amounts associated with unpaid co-pays or deductibles for individuals with third party coverage for the inpatient and/or outpatient hospital services they receive or any other unreimbursed costs associated with inpatient and/or outpatient hospital services provided to individuals with those services in their third party coverage benefit package. Nor does uncompensated care costs include bad debt or payer discounts related to services furnished to individuals who have health insurance or other third party payer.

(16) *Total annual uncompensated care costs.* The total annual uncompensated care cost equals the total cost of care for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individuals and to individuals with no source of third party coverage for the hospital services they receive less the sum of regular Medicaid FFS rate payments, Medicaid managed care organization payments, supplemental/enhanced Medicaid payments, uninsured revenues, and Section 1011 payments for inpatient and outpatient hospital services. This should equal the sum of paragraphs (c)(11) and (c)(15) subtracted from the sum of paragraphs (c)(9), (c)(12) and (c)(13) of this Section.

(17) *Disproportionate share hospital payments.* Indicate total annual payment adjustments made to the hospital under Section 1923 of the Act.

(18) States must report DSH payments made to all hospitals under the authority of the approved Medicaid State plan. This includes both in-State and out-of-State hospitals. For out-of-State hospitals, States must report, at a minimum, the information identified in

§ 447.299(c)(1) through (c)(6), (c)(8), (c)(9) and (c)(17).

* * * * *

PART 455—PROGRAM INTEGRITY: MEDICAID

■ 1. The authority citation for part 455 continues to read as follows:

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

■ 2. Add new subpart D to read as follows:

Subpart D—Independent Certified Audit of State Disproportionate Share Hospital Payment Adjustments

Sec.

Subpart D—Independent Certified Audit of State Disproportionate Share Hospital Payment Adjustments

§ 455.300 Purpose.

This subpart implements Section 1923(j)(2) of the Act.

§ 455.301 Definitions.

For the purposes of this subpart—

Independent certified audit means an audit that is conducted by an auditor that operates independently from the Medicaid agency or subject hospitals and is eligible to perform the DSH audit. Certification means that the independent auditor engaged by the State reviews the criteria of the Federal audit regulation and completes the verification, calculations and report under the professional rules and generally accepted standards of audit practice. This certification would include a review of the State's audit protocol to ensure that the Federal regulation is satisfied, an opinion for each verification detailed in the regulation, and a determination of whether or not the State made DSH payments that exceeded any hospital's specific DSH limit in the Medicaid State plan rate year under audit. The certification should also identify any data issues or other caveats that the auditor identified as impacting the results of the audit.

Medicaid State Plan Rate Year means the 12-month period defined by a State's approved Medicaid State plan in which the State estimates eligible uncompensated care costs and determines corresponding disproportionate share hospital payments as well as all other Medicaid payment rates. The period usually corresponds with the State's fiscal year or the Federal fiscal year but can correspond to any 12-month period defined by the State as the Medicaid State plan rate year.

§ 455.304 Condition for Federal financial participation (FFP).

(a) *General rule.* (1) The State must submit an independent certified audit to CMS for each completed Medicaid State plan rate year, consistent with the requirements in this subpart, to receive Federal payments under Section 1903(a)(1) of the Act based on State expenditures for disproportionate share hospital (DSH) payments for Medicaid State plan rate years subsequent to the date the audit is due, except as provided in paragraph (e) of this section.

(2) FFP is not available in expenditures for DSH payments that are found in the independent certified audit to exceed the hospital-specific eligible uncompensated care cost limit, except as provided in paragraph (e) of this section.

(b) *Timing.* For Medicaid State plan rate years 2005 and 2006, a State must submit to CMS an independent certified audit report no later than the last day of calendar year 2009. Each subsequent audit beginning with Medicaid State plan rate year 2007 must be completed by the last day of the Federal fiscal year ending three years from the end of the Medicaid State plan rate year under audit. Completed audit reports must be submitted to CMS no later than 90 days after completion. Post-audit adjustments based on claims for the Medicaid State plan rate year paid subsequent to the audit date, if any, must be submitted in the quarter the claim was paid.

(c) *Documentation.* In order to complete the independent certified audit, States must use the following data sources:

(1) Approved Medicaid State plan for the Medicaid State plan rate year under audit.

(2) Payment and utilization information from the State's Medicaid Management Information System.

(3) The Medicare 2552–96 hospital cost report(s) applicable to the Medicaid State plan rate year under audit. If the Medicare 2552–96 is superseded by an alternate Medicare developed cost reporting tool during an audit year, that tool must be used for the Medicaid State plan rate year under audit.

(4) Audited hospital financial statements and hospital accounting records.

(d) *Specific requirements.* The independent certified audit report must verify the following:

(1) *Verification 1:* Each hospital that qualifies for a DSH payment in the State is allowed to retain that payment so that the payment is available to offset its uncompensated care costs for furnishing inpatient hospital and outpatient hospital services during the Medicaid State plan rate year to Medicaid eligible individuals and individuals with no source of third party coverage for the services in order to reflect the total amount of claimed DSH expenditures.

(2) *Verification 2:* DSH payments made to each qualifying hospital comply with the hospital-specific DSH payment limit. For each audited Medicaid State plan rate year, the DSH payments made in that audited Medicaid State plan rate year must be measured against the actual uncompensated care cost in that same audited Medicaid State plan rate year.

(3) *Verification 3:* Only uncompensated care costs of furnishing inpatient and outpatient hospital services to Medicaid eligible individuals and individuals with no third party coverage for the inpatient and outpatient hospital services they received as described in Section 1923(g)(1)(A) of the Act are eligible for inclusion in the calculation of the hospital-specific disproportionate share limit payment limit, as described in Section 1923(g)(1)(A) of the Act.

(4) *Verification 4:* For purposes of this hospital-specific limit calculation, any Medicaid payments (including regular Medicaid fee-for-service rate payments, supplemental/enhanced Medicaid payments, and Medicaid managed care organization payments) made to a disproportionate share hospital for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individuals, which are in excess of the Medicaid incurred costs of such services, are applied against the uncompensated care costs of furnishing inpatient hospital and outpatient hospital services to individuals with no source of third party coverage for such services.

(5) *Verification 5:* Any information and records of all of its inpatient and outpatient hospital service costs under the Medicaid program; claimed expenditures under the Medicaid program; uninsured inpatient and outpatient hospital service costs in determining payment adjustments under this Section; and any payments made on behalf of the uninsured from payment adjustments under this Section has been separately documented and retained by the State.

(6) *Verification 6:* The information specified in paragraph (d)(5) of this Section includes a description of the methodology for calculating each hospital's payment limit under Section 1923(g)(1) of the Act. Included in the description of the methodology, the

audit report must specify how the State defines incurred inpatient hospital and outpatient hospital costs for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individuals and individuals with no source of third party coverage for the inpatient hospital and outpatient hospital services they received.

(e) *Transition Provisions:* To ensure a period for developing and refining reporting and auditing techniques, findings of State reports and audits for Medicaid State Plan years 2005–2010 will not be given weight except to the extent that the findings draw into question the reasonableness of State uncompensated care cost estimates used for calculations of prospective DSH payments for Medicaid State plan year 2011 and thereafter.

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

Dated: September 25, 2008.

Kerry Weems,

Acting Administrator, Centers for Medicare & Medicaid Services.

Approved: October 29, 2008.

Michael O. Leavitt,

Secretary.

Editorial Note: This document was received in the Office of the Federal Register on Friday, December 12, 2008.

[FR Doc. E8–30000 Filed 12–18–08; 8:45 am]

BILLING CODE 4120–01–P

Attachment 2:

Participating DSH: Addresses and Payments per Fiscal Year

Exhibit 2

SFY 10	SFY 11	(Estimated) SFY12	HOSPITAL FYE	TYPE	PROVIDER NAME	ADDRESS	CITY	ST	ZIP
303,655	218,306	403,598	6/30		BECKLEY APPALACHIAN REGIONAL HOSPITAL	306 STANAFORD RD	BECKLEY	WV	25801
246,265	182,116	183,240	6/30		BLUEFIELD REGIONAL MEDICAL CENTER (CHOW 3RD QTR SFY 11 @10/1/10)	500 CHERRY ST	BLUEFIELD	WV	24701
941,772	1,110,146	973,724	6/30	CAH	BOONE MEMORIAL HOSPITAL	701 MADISON AVE	MADISON	WV	25130
702,132	677,102	807,920	12/31	CAH	BRAXTON COUNTY MEMORIAL HOSPITAL	100 HOYMAN DR	GASSAWAY	WV	26624
722,028	976,356	976,356	12/31	CAH	BROADDUS HOSPITAL	PO BOX 930	PHILIPPI	WV	26416
8,730,070	10,072,590	9,554,724	9/30		CABELL-HUNTINGTON HOSPITAL	1340 HAL GREER BLVD	HUNTINGTON	WV	25701
448,890	305,128	310,220	6/30		CAMDEN-CLARK MEMORIAL HOSPITAL	PO BOX 718	PARKERSBURG	WV	26102
2,152,880	1,529,323	1,553,502	12/31		CHARLESTON AREA MEDICAL CENTER	501 MORRIS ST	CHARLESTON	WV	25325
319,296	216,448	223,324	12/31		CITY HOSPITAL	8261	MORGANTOWN	WV	26506
365,345	229,748	257,320	12/31		DAVIS MEMORIAL HOSPITAL	# 1 GORMAN AVE, PO BOX 1484	ELKINS	WV	26241
22,097	0	0	12/31		EYE AND EAR CLINIC	PO BOX 1306	CHARLESTON	WV	25328
246,345	176,111	187,378	12/31		FAIRMONT GENERAL HOSPITAL	1325 LOCUST AVE	FAIRMONT	WV	26554
1,294,836	1,307,262	1,265,216	6/30	CAH	GRAFTON CITY HOSPITAL	500 MARKET ST	GRAFTON	WV	26354
639,879	886,488	998,688	6/30	CAH 9/21/09	GRANT MEMORIAL HOSPITAL	PO BOX 1019	PETERSBURG	WV	26847
153,134	106,152	105,644	4/30		GREENBRIER VALLEY MEDICAL CENTER	202 MAPLEWOOD AVE, PO BOX 497	RONCEVERTE	WV	24970
190,668	274,798	448,384	6/30	CAH	HAMPSHIRE MEMORIAL HOSPITAL	549 CENTER ST	ROMNEY	WV	26757
115,176	107,359	135,488	9/30		HIGHLAND HOSPITAL	PO BOX 4107 300 - 56TH ST. SE	CHARLESTON	WV	25364
76,888	52,422	49,604	9/30		JACKSON GENERAL HOSPITAL	PO BOX 720 PINNELL ST	RIPLEY	WV	25271
2,508,356	2,901,030	2,967,928	12/31	CAH	JEFFERSON MEMORIAL HOSPITAL	8261	MORGANTOWN	WV	26506
286,330	187,164	186,756	9/30		LOGAN REGIONAL MEDICAL CENTER	20 HOSPITAL DR	LOGAN	WV	25601
8,546,571	7,596,196	7,678,168	6/30	STATE OWNED	MILDRED MITCHELL-BATEMAN HOSPITAL	PO BOX 448 1530 NORWAY AVE	HUNTINGTON	WV	25709
1,016,300	1,283,810	1,304,336	12/31	CAH	MINNIE HAMILTON HEALTH CARE CENTER	186 HOSPITAL DR	GRANTSVILLE	WV	26147
405,990	297,749	313,144	12/31		MONONGALIA GENERAL HOSPITAL	PO BOX 1615	MORGANTOWN	WV	26507
798,432	778,203	778,200	12/31	CAH	MONTGOMERY GENERAL HOSPITAL	PO BOX 270 401 WASHINGTON & 6TH AVE	MONTGOMERY	WV	25136
544,832	626,066	571,292	6/30	CAH	MORGAN COUNTY WAR MEMORIAL HOSPITAL(CHOW 3RD QTR SFY 11 @11/10/10)	109 WAR MEMORIAL DR	SPRINGS	WV	25411
40,776	18,943	18,828	12/31		MTN STATE BHS RIVER PARK HOSPITAL	1230 6TH AVE	HUNTINGTON	WV	25701
268,442	201,247	343,304	12/31		OHIO VALLEY GENERAL HOSPITAL	2000 EOFF ST	WHEELING	WV	26003
1,256,480	1,269,188	1,269,188	12/31	CAH	PLATEAU MEDICAL CENTER	430 MAIN ST	OAK HILL	WV	25901
200,834	130,438	128,264	9/30		PLEASANT VALLEY HOSPITAL	2520 VALLEY DR	POINT PLEASANT	WV	25550
678,624	703,647	721,800	6/30	CAH	POCAHONTAS MEMORIAL HOSPITAL	RT 2, BOX 52 W	BUCKEYE	WV	24924
1,663,244	1,447,953	1,412,772	6/30	CAH	POTOMAC VALLEY HOSPITAL OF WEST VIRGINIA	167 MINERAL ST	KEYSER	WV	26726
1,543,104	1,923,648	1,923,648	12/31	CAH	PRESTON MEMORIAL HOSPITAL	300 S. PRICE ST	KINGWOOD	WV	26537
296,296	215,826	212,538	6/30		PRINCETON COMMUNITY HOSPITAL	PO BOX 1369 203 12TH ST	PRINCETON	WV	24774
133,396	93,408	98,108	9/30		PUTNAM GENERAL HOSPITAL	1400 HOSPITAL DR	HURRICANE	WV	25526
386,962	269,484	295,678	5/31		RALEIGH GENERAL HOSPITAL	1710 HARPER RD	BECKLEY	WV	25801
99,412	65,528	65,278	9/30		REYNOLDS MEMORIAL HOSPITAL	800 WHEELING AVE	GLEN DALE	WV	26038
967,552	1,013,284	1,096,364	9/30	CAH	ROANE GENERAL HOSPITAL	200 HOSPITAL DR	SPENCER	WV	25276
695,392	875,374	845,368	12/31	CAH	SISTERSVILLE GENERAL HOSPITAL	314 SOUTH WELLS ST	SISTERSVILLE	WV	26175
243,644	162,510	166,064	7/31		ST. FRANCIS HOSPITAL	333 LAIDLEY ST	CHARLESTON	WV	25301
287,662	143,183	0	1/31		ST. JOSEPH'S HOSPITAL - PARKERSBURG	PO BOX 1824	PARKERSBURG	WV	26102
489,633	548,119	464,148	9/30		ST. JOSEPH'S HOSPITAL/BUCKHANNON	1 AMALIA DR	BUCKHANNON	WV	26201
849,575	609,748	635,114	9/30		ST. MARY'S MEDICAL CENTER, INC.	2900 FIRST AVE	HUNTINGTON	WV	25702
216,658	141,203	125,682	9/30		STONEWALL JACKSON MEMORIAL HOSPITAL	PO BOX 10; RT 4 230 HOSPITAL PLAZA	WESTON	WV	26452
491,188	405,693	415,836	6/30	CAH	SUMMERS COUNTY APPALACHIAN REGIONAL HOSPITAL	PO BOX 940, TERRACE ST	HINTON	WV	25951
226,413	152,282	152,022	12/31		SUMMERSVILLE MEMORIAL HOSPITAL	400 FAIRVIEW HEIGHTS RD	SUMMERSVILLE	WV	26651
428,091	278,188	281,568	9/30		THOMAS MEMORIAL HOSPITAL	4605 MACCORKLE AVE, S.W.	CHARLESTON	WV	25309
521,170	360,311	377,854	12/31		UNITED HOSPITAL CENTER, INC.	3 HOSPITAL DR; PO BOX 1680	CLARKSBURG	WV	26301
738,060	523,626	504,144	6/30	CAH	WEBSTER COUNTY MEMORIAL HOSPITAL, INC.	324 MILLER MOUNTAIN DR: PO BOX 0312	SPRINGS	WV	26288
258,794	172,523	163,350	6/30		WEIRTON MEDICAL CENTER, INC.	601 COLLIERS WAY	WEIRTON	WV	26062
7,273,911	6,660,636	7,777,004	6/30	STATE OWNED	WELCH COMMUNITY HOSPITAL	454 MCDOWELL ST	WELCH	WV	24801
10,786,455	11,060,356	11,011,524	12/31		WEST VIRGINIA UNIVERSITY HOSPITALS	8261	MORGANTOWN	WV	26506
66,804	46,432	45,604	6/30		WETZEL COUNTY HOSPITAL	PO BOX 510	MARTINSVILLE	WV	26155
491,627	371,045	384,956	9/30		WHEELING HOSPITAL, INC.	1 MEDICAL PK	WHEELING	WV	26003
10,170,796	11,156,852	11,072,670	6/30	STATE OWNED	WILLIAM R. SHARPE JR. HOSPITAL	936 SHARPE HOSPITAL RD	WESTON	WV	26452
255,276	179,782	173,414	9/30		WILLIAMSON MEMORIAL HOSPITAL	PO BOX 1980	WILLIAMSON	WV	25661
$73,804,638	$73,298,530	$74,367,276							

DATE WITH CAH DISIGNATION INDICATES CONVERSION TO CAH DURING AUDIT PERIOD

Attachment 3:

Centers for Medicare & Medicaid Services
42 CFR Parts 447 and 455
Medicaid Program; DSH Payments; Correcting Amendment

REQUEST FOR QUOTATION

[MED13004] [Audit Services – Disproportionate Share Hospital Program]

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 bodies. The NTTAA directs EPA to provide Congress, through OMB, explanations when the Agency decides not to use available and applicable voluntary consensus standards. This final action includes environmental monitoring and measurement as described in EPA's final SMMP. EPA will not require the use of specific, prescribed analytic methods for monitoring and managing the designated Sites. The Agency plans to allow the use of any method, whether it constitutes a voluntary consensus standard or not, that meets the monitoring and measurement criteria discussed in the final SMMP.

(10) Executive Order 12898: Federal Actions To Address Environmental Justice in Minority Populations and Low Income Populations

Executive Order 12898 (59 FR 7629) 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 determined that this final rule will not have disproportionately high and adverse human health or environmental effects on minority or low-income populations because it does not affect the level of protection provided to human health or the environment. EPA has assessed the overall protectiveness of designating the disposal Sites against the criteria established pursuant to the MPRSA to ensure that any adverse impact to the environment will be mitigated to the greatest extent practicable.

(11) Congressional Review Act

The Congressional Review Act (CRA), 5 U.S.C. 801 *et seq.*, as added by the Small Business Regulatory Enforcement Fairness Act of 1996, generally provides that before a rule may take effect, the agency promulgating the rule must submit a rule report, which includes a copy of the rule, to each House of the Congress and to the Comptroller General of the United States. EPA will submit a report containing this rule and other required information to the U.S. Senate, the U.S. House of Representatives, and the Comptroller General of the United States prior to publication of the rule in the **Federal Register**. A major rule cannot take effect until 60 days after it is published in the **Federal Register**. This action is not a "major rule" as defined by 5 U.S.C. 804(2). This rule will be effective thirty days from the date of publication in the **Federal Register**.

List of Subjects in 40 CFR Part 228

Environmental protection, Water pollution control.

Authority: This action is issued under the authority of Section 102 of the Marine Protection, Research, and Sanctuaries Act, as amended, 33 U.S.C. 1401, 1411, 1412.

Dated: April 9, 2009.

Michelle L. Pirzadeh,

Acting Regional Administrator, Region 10.

■ For the reasons set out in the preamble, chapter I, title 40 of the Code of Federal Regulations is amended as follows:

PART 228—[AMENDED]

■ 1. The authority citation for part 228 continues to read as follows:

Authority: 33 U.S.C. 1412 and 1418.

■ 2. Section 228.15 is amended by adding paragraph (n)(7) to read as follows:

§ 228.15 Dumping sites designated on a final basis.

* * * * *

(n) * * *

(7) Umpqua River, OR—North and South Dredged Material Disposal Sites.

(i) North Umpqua River Site.

(A) *Location:* 43°41'23.09" N, 124°14'20.28" W; 43°41'25.86" N, 124°12'54.61" W; 43°40'43.62" N, 124°14'17.85" W; 43°40'46.37" N, 124°12'52.74" W.

(B) *Size:* Approximately 1.92 kilometers long and 1.22 kilometers wide, with a drop zone which is defined as a 500-foot setback inscribed within all sides of the site boundary, reducing the permissible disposal area to a zone 5,300 feet long by 3,000 feet wide.

(C) *Depth:* Ranges from approximately 9 to 37 meters.

(D) *Primary Use:* Dredged material.

(E) *Period of Use:* Continuing Use.

(F) *Restrictions:* (*1*) Disposal shall be limited to dredged material determined to be suitable for ocean disposal according to 40 CFR 227.13, from the Umpqua River navigation channel and adjacent areas;

(*2*) Disposal shall be managed by the restrictions and requirements contained in the currently-approved Site Management and Monitoring Plan (SMMP);

(*3*) Monitoring, as specified in the SMMP, is required.

(ii) South Umpqua River Site.

(A) *Location:* 43°39'32.31" N, 124°14'35.60" W; 43°39'35.23" N, 124°13'11.01" W; 43°38'53.08" N, 124°14'32.94" W; 43°38'55.82" N, 124°13'08.36" W.

(B) *Size:* Approximately 1.92 kilometers long and 1.22 kilometers wide, with a drop zone which is defined as a 500-foot setback inscribed within all sides of the site boundary, reducing the permissible disposal area to a zone 5,300 feet long by 3,000 feet wide.

(C) *Depth:* Ranges from approximately 9 to 37 meters.

(D) *Primary Use:* Dredged material.

(E) *Period of Use:* Continuing Use.

(F) *Restrictions:* (*1*) Disposal shall be limited to dredged material determined to be suitable for ocean disposal according to 40 CFR 227.13, from the Umpqua River navigation channel and adjacent areas;

(*2*) Disposal shall be managed by the restrictions and requirements contained in the currently-approved Site Management and Monitoring Plan (SMMP);

(*3*) Monitoring, as specified in the SMMP, is required.

* * * * *

[FR Doc. E9–9434 Filed 4–23–09; 8:45 am]

BILLING CODE 6560–50–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 447 and 455

[CMS–2198–F2]

RIN–0938–AN09

Medicaid Program; Disproportionate Share Hospital Payments; Correcting Amendment

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

ACTION: Final rule; correcting amendment.

SUMMARY: This correcting amendment corrects a technical error in the regulations text in the final rule published in the **Federal Register** on December 19, 2008 (73 FR 77904) entitled, "Disproportionate Share Hospital Payments." In that final rule, we set forth data elements necessary to

REQUEST FOR QUOTATION

[MED13004] [Audit Services – Disproportionate Share Hospital Program]

comply with the requirements of section 1923(j) of the Social Security Act (the Act) related to auditing and reporting of disproportionate share hospital payments under State Medicaid programs. The effective date was January 19, 2009.

DATES: *Effective Date:* This correcting amendment is effective April 24, 2009.

FOR FURTHER INFORMATION CONTACT:
Venesa Day, (410) 786–8281.
Rory Howe, (410) 786–4878.
Rob Weaver, (410) 786–5914.

SUPPLEMENTARY INFORMATION:

I. Background

In FR Doc. E8–30000 issued on December 19, 2008 (73 FR 77904), there was a technical error that is identified and corrected in this correcting amendment. The correction in this document is effective April 24, 2009.

II. Summary of Error in the Regulations Text

On page 77950 of the final rule, we made a technical error in the regulation text of § 447.299(c)(16). In this paragraph, the text provides a narrative description of how "total annual uncompensated care costs" are to be calculated from component data elements. The first sentence accurately names the component data elements and correctly describes the calculation. The last sentence attempts to condense the previous sentence by substituting references for component data elements as identified in previous paragraphs of § 447.299(c). However, the references are unintentionally incorrect.

The last sentence of the original final text indicates that the sum of paragraphs (c)(11) and (c)(15) should be subtracted from (c)(9), (c)(12), and (c)(13). This calculation would sum Medicaid uncompensated care costs and total uninsured inpatient and outpatient uncompensated care costs, then subtract this total from the sum of total Medicaid inpatient and outpatient payments, uninsured inpatient and outpatient revenue, and total applicable Section 1011 payments. This calculation is incorrect and could not be interpreted reasonably to result in "total annual uncompensated care costs". Additionally, it erroneously contradicts section 1923(g) of the Social Security Act (the Act), § 447.299 and § 455 subpart D, and longstanding CMS policy.

The corrected text of the last sentence should read as follows: "This should equal the sum of paragraphs (c)(9), (c)(12), and (c)(13) subtracted from the sum of paragraphs (c)(10) and (c)(14) of this section." This correction includes the correct references necessary to calculate accurately "total uncompensated care costs" consistent with section 1923(g) of the Act, § 447.299 and § 455 Subpart D, and longstanding CMS policy.

IV. Waiver of Proposed Rulemaking and Delay in Effective Date

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** to provide a period for public comment before the provisions of a rule take effect in accordance with section 553(b) of the Administrative Procedure Act (APA) (5 U.S.C. 553(b)). However, we can waive this notice and comment procedure if the Secretary finds, for good cause, that the notice and comment process is impracticable, unnecessary, or contrary to the public interest, and incorporates a statement of the finding and the reasons therefore in the notice.

Section 553(d) of the APA ordinarily requires a 30-day delay in effective date of final rules after the date of their publication in the **Federal Register**. This 30-day delay in effective date can be waived, however, if an agency finds for good cause that the delay is impracticable, unnecessary, or contrary to the public interest, and the agency incorporates a statement of the findings and its reasons in the rule issued.

This action merely corrects a technical error in the December 19, 2008 final rule. We are not changing the policy contained in that rule, and further public comment is unnecessary. Therefore, we find there is good cause to waive notice and comment procedures and the 30-day delay in effective date for this action.

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, and Rural areas.

■ Accordingly, 42 CFR chapter IV is corrected by making the following correcting amendment to part 447:

PART 447—PAYMENTS FOR SERVICES

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

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

■ 2. Section 447.299 is amended by revising paragraph (c)(16) to read as follows:

§ 447.299 Reporting Requirements

(c) * * *

(16) *Total annual uncompensated care costs.* The total annual uncompensated care cost equals the total cost of care for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individuals and to individuals with no source of third party coverage for the hospital services they receive less the sum of regular Medicaid FFS rate payments, Medicaid managed care organization payments, supplemental/enhanced Medicaid payments, uninsured revenues, and Section 1011 payments for inpatient and outpatient hospital services. This should equal the sum of paragraphs (c)(9),(c)(12), and (c)(13) subtracted from the sum of paragraphs (c)(10) and (c)(14) of this section.

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

Dated: April 13, 2009.

Ashley Files Flory,

Acting Executive Secretary to the Department.

[FR Doc. E9–9232 Filed 4–23–09; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 300

[Docket No. 0812311655–9645–03]

RIN 0648–AX44

Pacific Halibut Fisheries; Catch Sharing Plan; Correction

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

ACTION: Final rule; correction.

SUMMARY: This action corrects the text of a final rule published on March 19, 2009, that implemented annual management measures governing the Pacific halibut fishery. This final rule established season dates off of Alaska, Washington, Oregon and California. This action is necessary to correct errors in dates listed in the areas from Leadbetter Point, WA to Cape Falcon, OR and from Cape Falcon to Humbug Mountain, OR.

DATES: Effective April 24, 2009.

FOR FURTHER INFORMATION CONTACT: Sarah Williams, 206–526–4646.

SUPPLEMENTARY INFORMATION: A final rule published March 19, 2009 (74 FR 11681), included annual management measures for managing the harvest of Pacific halibut (*Hippoglossus*

Attachment 4:

General DSH Auditing and Reporting Protocol

General DSH Audit and Reporting Protocol

Areas of Responsibility

States:

1. States are responsible for obtaining the independent audit on an annual basis
   - In response to the statutory language, "independent," audits must be certified by Single State Audit Agency or any other CPA firm that operates independently from the Medicaid agency and the subject hospitals. States may not rely on non-CPA firms, fiscal intermediary, independent certification programs currently in place to audit UCC, nor expand hospital financial statements to obtain audit certification of the hospital specific DSH limits.
   - The Single State Audit is an Office of Inspector General process. Although there may be some overlap in resources used to complete both audits, the DSH Audit is particular to Medicaid and is the sole responsibility of CMS to enforce and monitor and thus cannot be combined within the Single State Audit Act.
2. Providing the auditor and the DSH hospitals subject to audit with instructions on the data elements necessary to insure compliance
   - The DSH audit will rely on existing cost reporting tools and documents as primary sources for the data necessary to evaluate DSH payments against hospital specific DSH costs. Two of the primary source documents are the Medicare 2552-96 hospital cost report and audited hospital financial statements (and other auditable hospital accounting records). Rather than requiring that states or hospitals create new documents and potentially new financial standards, CMS will rely on the financial standards that apply to the use of these documents in their current form. Any hospital participating in the Medicare program already completes the Medicare 2552-96 cost report and is familiar with the accounting standards applicable to this document. Similarly, hospital financial statements are subject to certain financial reporting standards to produce the information that will be used in the DSH audit. Each of these documents will produce data used to develop cost and payment information for the DSH audit using the financial reporting standards applicable to each.
   - Developing audit protocol for use by DSH hospitals to determine costs. This protocol should include instructions identifying the relevant sections of the cost report that reflect costs eligible for inclusion in developing the hospital specific DSH limit and must replace any current DSH survey information utilized by states. This protocol should include identification of all relevant hospital cost reports and financial statements and other auditable hospital accounting records associated with the audited Medicaid State plan rate year. Situations in which a hospitals fiscal year does not coincide with the Medicaid State plan rate year, hospitals will need to provide the two (or more, if there are short-period, i.e., less than twelve-month, cost reports involved)

overlapping cost reports and financial statements and other auditable hospital accounting records to properly reflect cost incurred during the full State Plan rate year.

3. Provide DSH hospitals and auditor with fee for service (FFS) Medicaid IP and OP hospital days and charges based on Medicaid Management Information System (MMIS) data for the cost reporting period(s) covering the Medicaid State plan rate year under audit.
4. Provide DSH hospitals and auditor with all information related to IP/OP hospital regular Medicaid rate payments (including all rate add-ons), all Medicaid supplemental and enhanced payments, and all DSH payments made to each DSH hospital for the cost reporting year(s) covering the State plan rate year.
5. Provide auditor with methodologies utilized by the State to determine DSH eligible hospitals under the Medicaid State plan (LIUR, MIUR, Other) and payment methodologies used to generate DSH payments under the approved Medicaid State plan.
6. Provide auditor with hospital-generated IP/OP hospital cost report information; Medicaid managed care IP/OP hospital days, charges, and payment information; and uninsured IP/OP hospital days, charges, and payment information received from DSH hospitals.
7. Report the findings of the audit to CMS within 90 days of receiving audit. In recognition of timing issues related to initiating the audit process. States may concurrently complete the Medicaid State plan rate year 2005 and 2006 audits by September 30, 2009. The report associated with Medicaid State plan rate years 2005 and 2006 are due no later than December 31, 2009 to CMS.
8. Use audit findings for rate year 2005 – 2010 to prospectively adjust DSH payments beginning with Medicaid State plan rate year 2011.
9. Use audit findings for rate year 2011 to determine over/underpayments (final report available in 2014).

DSH Hospitals:

1. Use the Medicare 2552-96 hospital cost report to determine cost center specific routine per diems and ancillary ratios of cost to charges (RCC) based on Medicare Cost Principles (Medicare cost allocation process).
2. Utilize MMIS data provided by the state for Medicaid FFS IP/OP hospital ancillary charges and Medicaid FFS IP hospital routine days.
3. Utilize hospital financial statements and other auditable hospital accounting records as source for IP/OP hospital Medicaid managed care ancillary charges and routine days and IP/OP hospital uninsured ancillary charges and routine days (individuals with no source of third party coverage). These charges and days will be used with cost center specific RCCs and per diems, respectively, to allocate hospital costs to each relevant payer category described above.
4. Utilize revenue information from financial statements and other auditable hospital accounting records to identify payments made by or on behalf of patients with no

source of third party coverage for IP/OP hospital services. Note that payments for IP/OP hospital services from state-only or local-only programs for the uninsured should not be included as revenues.

5. Utilize revenue information from financial statements and other auditable hospital accounting records to identify Medicaid payments not directly paid by the State in which the hospital is located, including all IP/OP Title XIX payments from other States (regular, supplemental and enhanced and DSH), all payments from Medicaid managed care organizations for IP/OP hospital services provided to Medicaid MCO enrollees, and all payments from other non-State sources for Medicaid IP/OP hospital services.
6. Provide state with hospital specific cost and revenue data, including backup documentation, so that independent auditor may utilize in developing audit report. Continue to provide state information already required to determine DSH qualifications (LIUR, MIUR, other).

Auditor:

1. Review State's methodology for estimating hospital's OBRA 1993 hospital-specific DSH limit and the State's DSH payment methodologies in the approved Medicaid State plan for the State plan rate year under audit.
2. Review state's DSH audit protocol to ensure consistency with IP/OP Medicaid reimbursable services in the approved Medicaid State plan. Review DSH audit protocol to ensure that only costs eligible for DSH payments are included in the development of the hospital specific DSH limit.
3. Compile hospital specific IP/OP cost report data and IP/OP revenue data to measure hospital specific DSH limit in auditable year. In determining this limit, the auditor must measure both components of the hospital specific DSH limit. To determine the existence of a Medicaid shortfall, Medicaid IP/OP hospital costs (including Medicaid managed care costs) must be measured against Medicaid IP/OP revenue received for such services in the audited State Plan rate year (including regular Medicaid rate payments, add-ons, supplemental and enhanced payments and Medicaid managed care revenues). Costs associated with patients with no source of third party coverage must be reduced by applicable revenues and added to any Medicaid shortfall to determine total eligible DSH costs.
4. Compile total DSH payments made in auditable year to each qualifying hospital (including DSH payments received by the hospitals from other States).
5. Compare hospital specific DSH costs limits against hospital specific total DSH payments in the audited Medicaid State plan rate year. Summarize findings identifying any overpayments/underpayments to particular hospitals.

Data Sources:

The following are to be considered the primary data sources utilized by states, hospitals and the independent auditors to complete the DSH audit and the accompanying report. In many instances, hospital financial and cost report periods will differ from the Medicaid

State plan rate year. In these instances, hospitals should use multiple audited financial reports and hospital cost reports to fully cover the Medicaid State plan rate year under audit. The data should be directly allocated based on the months covered by the financial or cost reporting period that directly related to the Medicaid State plan period under audit. For instance, if a Medicaid State plan rate year runs from 7/1/04 to 6/30/05 but a DSH hospital receiving payments under the Medicaid State plan operates its financial and cost reporting based on a calendar year, the hospital would need to use financial and cost reports for calendar years 2004 and 2005. The hospital would allocate 50% of all costs and revenues in each financial and cost reporting period to determine costs and revenues associated with the Medicaid State plan rate year 2005.

1. **MMIS Data**
   - State MMIS generated IP hospital payments, ancillary charges and routine days for the cost reporting period(s) covering the Medicaid State plan rate year under audit for each DSH hospital.
   - State MMIS generated OP hospital payments and ancillary charges for the cost reporting period(s) covering the Medicaid State plan rate year under audit for each DSH hospital.

2. **Approved Medicaid State Plan**
   - LIUR, MIUR or other DSH hospital determination criteria and data used to determine eligibility for the Medicaid State plan rate year under audit.
   - Medicaid State Plan DSH payment methodologies for the Medicaid State plan rate year under audit.
   - State DSH payments to each DSH hospital for the Medicaid State plan rate year under audit.
   - State methodology for determining the hospital-specific DSH limit, the data used to determine such limit and the hospital-specific cost limit generated by methodology and data for the Medicaid State plan rate year under audit.

3. **Medicare 2552-96 Hospital Cost Report**
   - Medicare 2552-96 hospital cost report(s) for the Medicaid State plan rate year under audit (finalized when available, or as filed).

4. **Audited Hospital Financial Statements and Other Auditable Hospital Accounting Records**
   - Hospital revenues from Medicaid managed care organizations, Medicaid payments from other States (regular payments including add-ons, supplemental and enhanced payments, DSH payments), and Medicaid IP/OP hospital payments from all sources other than the State from hospital financial reports and records for the cost reporting period(s) covering the Medicaid State plan rate year under audit.
   - Hospital revenues from or on behalf of with no source of third party coverage for the hospital services provided.

- Days and charges for IP/OP Medicaid hospital services for services provided to out of state Medicaid patients.
- Days and charges for IP/OP hospital services provided to patients with no source of third party coverage for the hospital services provided.
- Days and charges for IP/OP hospital services provided to Medicaid managed care patients.

General Cost Determination: Uncompensated Care Cost Determination

Hospitals must use the Medicare 2552-96 Hospital Cost Report(s) for the Medicaid State plan rate year to determine allowable IP/OP Medicaid service costs and costs of providing IP/OP hospital services to patients with no source of third party coverage for the hospital services provided.

The Medicare cost allocation process will be used to determine facility costs for inclusion in determining DSH eligible hospital costs. In order to provide complete financial information for the Medicaid State plan rate year under audit, hospitals must use two or more Medicare costs reports if the cost reporting period does not correspond with the Medicaid State plan rate year under audit. Once costs are allocated according to the Medicare cost allocation process, those costs should be allocated to the Medicaid State plan rate year on a pro-rata basis to develop 12 full months of costs.

1. Hospitals determine IP FFS Medicaid costs
   Hospitals must follow the cost reporting and apportionment process as prescribed by the 2552-96. In the 2552-96, a per diem is computed for each routine cost center, and a cost-to-charge ratio is computed for each ancillary/non-routine cost center. In the Worksheet D series of the 2552-96, total allowable costs from each routine cost center are apportioned to a specific program by applying that cost center's program days to the cost center's computed per diem, and total allowable costs from each ancillary/non-routine cost center are apportioned to a specific program by applying that cost center's program charges to the cost center's computed cost-to-charge ratio.

   The program data used in this apportionment process in determining hospital inpatient fee-for-service Medicaid costs are the days and charges pertaining to hospital inpatient services furnished to Medicaid fee-for-service individuals. The primary source of the program data is the MMIS. The program days and charges must pertain: a) only to services furnished by the hospital and its departments and not by any non-hospital component (even if such component is deemed to be hospital-based); b) only to inpatient hospital services and not services furnished by practitioners which can be billed separately as professional services; and c) only to services paid by Title XIX fee-for-service. As required by the 2552-96

cost report apportionment process, the program data must be reported by hospital cost centers.

By applying program days defined above to the cost-report-computed per diems and applying program charges defined above to the cost report-computed cost-to-charge ratios, and by following the established 2552-96 cost reporting and apportionment process, the hospital will determine its hospital inpatient fee-for-service Medicaid cost

2. Hospitals determine IP Medicaid managed care costs
Hospitals must follow the cost reporting and apportionment process as prescribed by the 2552-96. In the 2552-96, a per diem is computed for each routine cost center, and a cost-to-charge ratio is computed for each ancillary/non-routine cost center. In the Worksheet D series of the 2552-96, total allowable costs from each routine cost center are apportioned to a specific program by applying that cost center's program days to the cost center's computed per diem, and total allowable costs from each ancillary/non-routine cost center are apportioned to a specific program by applying that cost center's program charges to the cost center's computed cost-to-charge ratio.

The program data used in this apportionment process in determining hospital inpatient Medicaid managed care costs are the days and charges pertaining to hospital inpatient services furnished to individuals under Medicaid managed care. The program data must be derived from auditable documentation and may include reports from Medicaid managed care plans. The auditable documentation must show that the program days and charges pertain: a) only to services furnished by the hospital and its departments and not by any non-hospital component (even if such component is deemed to be hospital-based); b) only to inpatient hospital services and not services furnished by practitioners which can be billed separately as professional services; and c) only to Title XIX services paid by the Medicaid managed care plans. As required by the 2552-96 cost report apportionment process, the program data must be reported by hospital cost centers.

By applying program days defined above to the cost-report-computed per diems and applying program charges defined above to the cost-report-computed cost-to-charge ratios, and by following the established 2552-96 cost reporting and apportionment process, the hospital will determine its hospital inpatient Medicaid managed care cost.

3. Hospitals determine IP costs for hospital services provided to patients with no source of third party coverage
Hospitals must follow the cost reporting and apportionment process as prescribed by the 2552-96. In the 2552-96, a per diem is computed for each routine cost

center, and a cost-to-charge ratio is computed for each ancillary/non-routine cost center. In the Worksheet D series of the 2552-96, total allowable costs from each routine cost center are apportioned to a specific program by applying that cost center's program days to the cost center's computed per diem, and total allowable costs from each ancillary/non-routine cost center are apportioned to a specific program by applying that cost center's program charges to the cost center's computed cost-to-charge ratio.

The program data used in this apportionment process in determining hospital uninsured inpatient costs are the days and charges pertaining to hospital inpatient services furnished to individuals who have no source of third party coverage. The program data must be derived from auditable documentation. The auditable documentation must show that the program days and charges pertain: a) only to services furnished by the hospital and its departments and not by any non-hospital component (even if such component is deemed to be hospital-based); b) only to inpatient hospital services and not services furnished by practitioners which can be billed separately as professional services; and c) only to services furnished to individuals who have no source of third party coverage (services furnished to individuals who are covered only by state-only/local governmental programs may be included). As required by the 2552-96 cost report apportionment process, the program data must be reported by hospital cost centers.

By applying the program days defined above to the cost-report-computed per diems and applying the program charges defined above to the cost-report-computed cost-to-charge ratios, and by following the established 2552-96 cost reporting and apportionment process, the hospital will determine its hospital uninsured inpatient cost.

4. Hospitals determine OP FFS Medicaid costs
Hospitals must follow the cost reporting and apportionment process as prescribed by the 2552-96. In the 2552-96, a cost-to-charge ratio is computed for each ancillary/non-routine cost center. In the Worksheet D series of the 2552-96, total allowable costs from each ancillary/non-routine cost center are apportioned to a specific program by applying that cost center's program charges to the cost center's computed cost-to-charge ratio.

The program data used in this apportionment process in determining hospital outpatient fee-for-service Medicaid costs are the charges pertaining to hospital outpatient services furnished to Medicaid fee-for-service individuals. The primary source of the program data is the MMIS. The program charges must pertain: a) only to services furnished by the hospital and its departments and not by any non-hospital component (even if such component is deemed to be hospital-based); b) only to outpatient hospital services furnished and not services furnished by practitioners which can be billed separately as professional services;

and c) only to services paid by Title XIX fee-for-service. As required by the 2552-96 cost report apportionment process, the program data must be reported by hospital cost centers.

By applying the program charges defined above to the cost-report-computed cost-to-charge ratios and by following the established 2552-96 cost reporting and apportionment process, the hospital will determine its hospital outpatient fee-for-service Medicaid cost.

5. Hospitals determine OP Medicaid managed care costs
Hospitals must follow the cost reporting and apportionment process as prescribed by the 2552-96. In the 2552-96, a cost-to-charge ratio is computed for each ancillary/non-routine cost center. In the Worksheet D series of the 2552-96, total allowable costs from each ancillary/non-routine cost center are apportioned to a specific program by applying that cost center's program charges to the cost center's computed cost-to-charge ratio.

   The program data used in this apportionment process in determining hospital outpatient Medicaid managed care costs are the charges pertaining to hospital outpatient services furnished to individuals under Medicaid managed care. The program data must be derived from auditable documentation and may include reports from Medicaid managed care plans. The auditable documentation must show that the program charges pertain: a) only to services furnished by the hospital and its departments and not by any non-hospital component (even if such component is deemed to be hospital-based); b) only to OP hospital services and not services furnished by practitioners which can be billed separately as professional services; and c) only to Title XIX services paid by the Medicaid managed care plans. As required by the 2552-96 cost report apportionment process, the program data must be reported by hospital cost centers.

   By applying program charges defined above to the cost-report-computed cost-to-charge ratios and by following the established 2552-96 cost reporting and apportionment process, the hospital will determine its hospital outpatient Medicaid managed care cost.

6. Hospitals determine OP costs for hospital services provided to patients with no source of third party coverage
Hospitals must follow the cost reporting and apportionment process as prescribed by the 2552-96. In the 2552-96, a cost-to-charge ratio is computed for each ancillary/non-routine cost center. In the Worksheet D series of the 2552-96, total allowable costs from each ancillary/non-routine cost center are apportioned to a specific program by applying that cost center's program charges to the cost center's computed cost-to-charge ratio.

The program data used in this apportionment process in determining hospital uninsured outpatient costs are the charges pertaining to hospital outpatient services furnished to individuals who have no source of third party coverage. The program data must be derived from auditable documentation. The auditable documentation must show that the program charges pertain: a) only to services furnished by the hospital and its departments and not by any non-hospital component (even if such component is deemed to be hospital-based); b) only to OP hospital services and not services furnished by practitioners which can be billed separately as professional services; and c) only to services furnished to individuals who have no source of third party coverage (services furnished to individuals who are covered only by state-only/local governmental programs may be included). As required by the 2552-96 cost report apportionment process, the program data must be reported by hospital cost centers.

By applying the program charges defined above to the cost-report-computed cost-to-charge ratios and by following the established 2552-96 cost reporting and apportionment process, the hospital will determine its hospital uninsured outpatient cost.

7. Hospital report revenues from Medicaid managed care organizations, Medicaid payments from other States (regular payments including add-ons, supplemental and enhanced payments, DSH payments), and other non-State Medicaid payments
Since the State's MMIS system will not have information about payments generated from Medicaid managed care organizations or Medicaid and DSH payments from other States and other non-State sources, hospitals must use their financial statements and other auditable hospital accounting records to identify:
   - All Medicaid managed care payments received during the cost reporting period(s) covering the Medicaid State plan rate year under audit. Any managed care payments received that include payments for services other than those that qualify for IP or OP hospital services must be separated to include that portion of the payment applicable to IP or OP hospital services. If the hospital cannot separate the component parts of a managed care payment, the full amount of the payment must be counted as in IP/OP hospital managed care payment.
   - All Medicaid payments received from out of state during the cost reporting period(s) covering the Medicaid State Plan rate year under audit. Hospitals must separately identify a) Medicaid regular rate payments (including add-ons); b) supplemental Medicaid payments, and; c) DSH payments.
   - All Medicaid payments received during the cost reporting period(s) covering the Medicaid State plan rate year under audit from non-State sources not already accounted for, including payments from or on behalf of patients for Medicaid services.

8. Hospital report revenue from or on behalf of patients with no source of third party coverage for the hospital services provided
   Since the State's MMIS system will not have information about payments by or on behalf of patients with no source of third party coverage for the hospital services provided, hospitals must use their financial statements and other auditable hospital accounting records to identify:
   - All payments received during cost reporting period(s) covering the Medicaid State plan rate year under audit by or on behalf of patients with no source of third party coverage. There will be no attempt to allocate payments received during the state plan rate year to services provided in prior periods. Since the goal of the audit is to determine uncompensated DSH costs in a given Medicaid State plan rate year, all payments received in the year will be counted as revenue to the hospital in that same year. It is understood that some costs incurred during the State Plan rate year under audit may be associated with future revenue streams (legal decisions, payment plans, recoveries) but that the payments are not counted as revenue until actually received.
   - IP or OP hospital payments received from state or local government programs for individuals with no source of third party coverage for the hospital services they received should not be included as a revenue in this category.

9. Auditor applies MMIS generated total IP/OP hospital Medicaid FFS payments (other than DSH) to total IP/OP hospital Medicaid FFS cost

10. Auditor applies IP/OP hospital Medicaid managed care revenues against IP/OP hospital Medicaid managed care costs

11. Auditor applies IP/OP hospital revenues for patients with no source of third party coverage against the costs for IP/OP hospital services provided to such individuals

12. Sum of steps 9-11 are summed to determine the total amount of costs eligible for DSH reimbursement and considered the OBRA 1993 hospital specific DSH limit

13. Compare DSH payments to the amount determined in step 12

Attachment 5:

Additional CMS Correspondence

Department of Health & Human Services
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

Dear State Medicaid Director:

This letter provides operational guidance to States that may need additional time to complete the reporting and audit requirements as implemented in the December 19, 2008 Medicaid Disproportionate Share Hospital (DSH) final rule (73 FR 77904). The letter also clarifies the application of reporting requirements for data in past Medicaid State plan rate years as well as the auditor independence standard.

Background

On December 19, 2008, the Centers for Medicare & Medicaid Services (CMS) promulgated CMS-2198-F: Medicaid Program: Disproportionate Share Hospital Payments, with an effective date of January 19, 2009. The final rule implements Section 1001 of the Medicare Drug, Improvement and Modernization Act of 2003, requiring State reports and audits to ensure the appropriate use of Medicaid DSH payments and compliance with the statutorily imposed hospital-specific limits. In order to receive Federal financial participation (FFP) for DSH expenditures, States must submit an annual report and an independent certified audit to CMS for each completed Medicaid State plan rate year.

Pursuant to the provisions of the regulation, audits must begin with Medicaid State plan year 2005 and must be completed for the State plan rate years 2005 and 2006 no later than September 30, 2009. Each subsequent report and audit beginning with Medicaid State plan rate year 2007 must be completed by the last day of the Federal fiscal year (September 30) ending three years from the end of the Medicaid State plan rate year under audit. States must submit reports and audits to CMS within 90 days of the completion of the audit. Audits and reports for State plan rate years 2005 and 2006 are due to CMS on or before December 31, 2009. A State's failure to complete the audits and required reporting by the specified deadlines would put FFP for that State's DSH expenditures at risk.

To ensure a period for developing and refining reporting and auditing techniques, findings of State reports and audits for Medicaid State Plan years 2005-2010 will not be given weight except to the extent that the findings draw into question the reasonableness of State uncompensated care cost estimates used for calculations of prospective DSH payments for Medicaid State plan year 2011 and thereafter. After this transition period, FFP will not be available for expenditures for DSH payments that are found in the audit to exceed the hospital-specific eligible uncompensated care cost limit.

CMS Enforcement Strategy

Recently several States have indicated concern that, despite good faith efforts, they would be unable to meet the December 31, 2009 deadline for the first audit reports which pertain to 2005 and 2006 State plan rate years. These States cited a number of reasons, including the following: the rule's publication date fell outside of some state budget cycles so that those States could not plan for and budget completion of an independent audit for this year; the economic downturn has created a hardship on many State Medicaid agency budgets; States do not have the staff or financial resources to complete the 2005 and 2006 audits by year end; much of the data, particularly data related to uninsured costs and Medicaid managed care costs/payments, is currently housed entirely by hospitals; and the methodologies and calculations specified in the rule for determining costs differ from those used by the States during past Medicaid State plan rate years.

In light of these concerns, CMS has determined that it will apply a flexible enforcement strategy designed to ensure that States have sufficient time to properly implement the new requirements without undue hardship. Thus, CMS will not find a State to be out of compliance with the DSH reporting and auditing requirements for the initial (2005 and 2006) Medicaid State plan rate years until December 31, 2010. We do not anticipate any further delay of compliance enforcement, or any delay of compliance enforcement for subsequent audit years.

Even though CMS will be delaying compliance enforcement, CMS expects that States will be making good faith efforts to comply with the new requirements. We ask each State to identify, and to provide in writing to its respective CMS Associate Regional Administrator, a contact individual by September 30, 2009 to brief CMS representatives on the State's compliance status and progress. Based on those discussions, some States may be asked for detailed information about compliance efforts.

Additional Clarifications

The CMS is also using this opportunity to clarify more formally CMS' expectations with respect to reporting for past State plan rate years and the auditor independence standard.

Data

We have heard numerous concerns from States and hospitals that the audit and reporting requirements are extraordinarily burdensome in the initial years because States and hospitals cannot extract specific data for the reporting elements retroactively from the accounting systems used in prior years. When presented with these concerns, we have clarified to States that reports and audits should be based on the best available information. Our goal is that States will be able to fully and accurately report on these elements by the end of the transition period.

Generally, we expect most data elements necessary for the State to complete the DSH audit and report to be information States and hospitals already collect to assure that their DSH programs are compliant with Medicaid law. However, specific data elements required within the reports may be difficult for hospitals and States to accurately extract from existing reports and data systems for past State plan rate years. Anticipating such constraints, CMS included the transition period to allow States, providers and auditors time to refine reporting and auditing techniques. To the extent that States and hospitals are unable to report directly on elements for past Medicaid State plan rate years, they should include the best available information. During the transition period, CMS will work with States that make a good faith effort to fulfill all of the DSH reporting and auditing requirements. However, States and hospitals should be working to modify systems such that they will be able to report more exactly for each element prospectively.

Auditor Independence

A number of States have also raised concerns about the cost or difficulty in procuring an independent auditor to conduct the required independent certified DSH audit. We have advised States that there are a wide number of auditing arrangements which would be acceptable under these standards, some of which may be less burdensome and costly than the use of private auditing firms, including the use of state government auditing agencies. However, there appears to be continuing confusion about this standard among States.

Medicaid regulations at 42 CFR 455.301 define a certified independent audit in part to mean an audit that is conducted by an auditor that operates independently from the Medicaid agency or subject hospital. We read this requirement to be consistent with established standards within the auditing profession which guide auditors and their clients with respect to independence and impairments to independence that might potentially compromise the integrity of the audit. Specifically, CMS advises States to review and apply the General Accounting Office's most recent revision to Government Auditing Standard specific criteria for independence government auditing practices (http://www.gao.gov/govaud/govaudhtml/index.html). These standards assure integrity while allowing flexibility to States.

We appreciate States' ongoing efforts to implement the DSH reporting and independent audits requirements. If you have questions or would like additional information on this guidance, please contact Cheryl Powell, Division of Reimbursement and State Financing, Financial Management Group via email at Cheryl.Powell@cms.hhs.gov or by phone at (410)786-9239.

Sincerely,

Jackie Garner

Attachment 6:

Additional CMS Correspondence on DSH Reporting and Audit Requirements

Additional Information on the DSH Reporting and Audit Requirements

Best Available Information/Cost Report Procedures

1. **How can an independent auditor certify that DSH payments do not exceed the hospital-specific DSH limits if data used for calculating the limits is derived, at least in part, from as-filed Medicare cost reports?**

Certification means that the independent auditor engaged by the State follows the criteria of the Federal audit regulation and completes the verification, calculations and report under the professional rules and generally accepted standards of audit practice. This certification would include an assessment of the State's audit protocol to ensure that the Federal regulation is satisfied, an opinion for each verification detailed in the regulation, and a determination of whether or not the State made DSH payments that exceeded any hospital-specific DSH limit in the Medicaid State plan rate year under audit. The certification should also identify any data issues or other caveats that the auditor identified as impacting the results of the audit.

We expect that reports and audits will be based on the best available information. If audited Medicare cost reports are not available within the timeframe allowed for the reporting and audit submission, the DSH report and audit may need to be based on Medicare cost reports as filed. However, in the final rule, CMS modified the timeline for report and audit submission to allow States additional time for the inclusion of the most accurate and complete data possible. The required reports and audits may be submitted as late as the last day of the Federal fiscal year ending three years after the end of the Medicaid State plan rate year, with a special timing provision for the audits for 2005 and 2006, which will be due by December 31, 2009. Additionally, CMS has developed a General DSH Audit and Reporting Protocol that should assist States and auditors in utilizing information from each data source and developing methods to determine uncompensated costs of furnishing hospital services to the Medicaid and uninsured populations. The protocol is available on the CMS website at www.cms.hhs.gov/MedicaidGenInfo/Downloads/CMS2198FRptProtocol.pdf.

It should be noted that in light of States' concerns regarding budget cycles, planning complications, and the economic downturn, CMS has determined that it will apply a flexible enforcement strategy designed to ensure that States have sufficient time to properly implement the new requirements without undue hardship. Thus, CMS will not find a State to be out of compliance with the DSH reporting and auditing requirements for the initial (2005 and 2006) Medicaid State plan rate years until December 31, 2010. Pursuant to the provisions of the regulation, independent audits must begin with Medicaid State plan year 2005 and must be completed no later than September 30, 2009, for the State plan rate years 2005 and 2006. Audits and reports for State plan rate years 2005 and 2006 are due to CMS on or before December 31, 2009.

2. **If as-filed Medicare cost reports are used to calculate hospital-specific DSH limits, do limits have to be adjusted to reflect the final settlement of the cost report or the outcome of cost report appeals?**

We expect that reports and audits will be based on the best available information. If audited Medicare cost reports are not available, the DSH report and audit may need to be based on Medicare cost reports as filed. Most hospital cost reports are finalized within two years of the period being audited but there is always the possibility of post-audit adjustments. To the extent that such adjustments to cost reports affects Medicaid payments, States should notify CMS of the adjustments to the cost reports and any subsequent DSH audit report changes as well as make appropriate prior period adjustments through the MBES/CBES system. Additionally, we would anticipate the auditor's certification would identify any data issues or other caveats that the auditor has identified as impacting the results of the audit.

The statutory authority instructed States to report and audit specific payments and specific costs. Consistent with that provision, States must perform audits associated with defined periods of time and must identify the actual costs incurred and payments received during that defined time period. In order for the audits to properly measure these elements and in consideration of the many comments related to retroactivity and timing issues associated with gathering the data necessary to identify the costs and revenues, CMS has made several revisions to the final rule including identifying that: (i) the Medicaid State plan rate year 2005 is the first time period subject to the audit; and, (ii) the deadline on reporting the audit findings has been extended to at least three full years after the close of the Medicaid State plan rate year subject to audit.

The required reports and audits may be submitted as late as the last day of the Federal fiscal year ending three years after the end of the Medicaid State plan rate year, with a special timing provision for the audits for 2005 and 2006, which will be due by December 31, 2009. This three year period accommodates the one-year concern expressed in many comments regarding claims lags and is consistent with the varying cost report period and adjustments.

3. **Data derived from multiple cost report years might have to be used in fulfilling audit and reporting requirements for a given State plan rate year. In order to complete reporting and auditing requirements relating to State plan rate years 2005 and 2006, for the 2005 and 2006 reports, would it be acceptable to obtain 2004 and 2007 costs from submitted or unreviewed cost reports?**

In instances where the hospital financial and cost reporting periods differ from the Medicaid State plan rate year, States and auditors may need to evaluate multiple audited hospital financial reports and cost reports to fully cover the Medicaid State plan rate year under audit. Typically, at most, two financial and/or cost reports should provide the appropriate data. Please note that there are some circumstances where more than two cost reports are needed to cover a State plan year. Some occasions call for a hospital to file short-period cost reports within a normal 12-month cost reporting period. For example, if there is a change of ownership in the middle of a fiscal period, the hospital will have to file more than one cost report during its 12-month fiscal period. The data may need to be allocated based on the months covered by the financial or cost reporting period that are included in the Medicaid State plan period under audit. CMS has developed a General DSH Audit and Reporting Protocol to assist States in using the information from each source identified above and developing the methods under which costs and revenues will be determined. The protocol is available on the CMS website at www.cms.hhs.gov/MedicaidGenInfo/Downloads/CMS2198FRptProtocol.pdf.

We expect that all reports and audits will be based on the best available information. If audited Medicare cost reports are not available, the DSH report and audit may need to be based on Medicare cost reports as

filed. Moreover, in order to ensure a period for developing and refining audit practices, we are providing for a transition period through Medicaid State plan rate year 2010, before audit results will be given weight other than in making prospective estimates of hospital costs for the purposes of ongoing DSH payments.

4. **Can independent auditors utilize a risk-based approach to auditing hospitals or utilize some materiality guideline in developing different levels of data analysis for different hospitals? Additionally, does CMS expect that all hospitals are audited by the independent auditor annually?**

The DSH audit and report is a necessary part of the administration of the Medicaid program. The purpose of the audit is to ensure that States make DSH payments under their Medicaid program that are in compliance with section 1923 of the Act. The audit does not encompass the review of the State's overall Medicaid program; it simply ensures that one portion of the program is conducted in line with Federal statutory limits. In addition, the DSH audit will rely on financial and cost report data provided by hospitals that are subject to generally accepted accounting principles as part of their primary reporting function.

There is no statutory authorization for an exception to audit and reporting requirements with respect to hospitals that receive DSH payments. The audit and reporting requirements under section 1923(j) of the Act apply to all States that make DSH payments, with respect to each hospital receiving a DSH payment. The statute further requires that CMS obtain information sufficient to verify that such payments are appropriate. Relying on a sample of cost reports and financial information will not ensure that each DSH payment is appropriate and does not exceed the hospital-specific DSH limit.

The data elements necessary for the State to complete the DSH audit and report should, in part, be information the State already gathers to administer the DSH program. The responsibility of the auditor is to measure DSH payments received by a hospital in a particular year against the eligible uncompensated care costs of that hospital in that same year as determined using the data provided in the cost, utilization and financial reporting documents described in the preamble to the final rule. Additionally, auditing a State's overall DSH payment methodology will not ensure that DSH payments to each hospital do not exceed the statutorily required hospital-specific DSH limit.

Finally, in order to certify to the verifications, the auditors should follow generally accepted auditing practices and requirements to assure a thorough and complete audit has been conducted. The auditor must develop sufficient confidence in the data to certify the results for the State plan rate year subject to the audit. The final rule does not eliminate any flexibility that independent auditors might have in using accepted professional methodologies to conduct the audit and to certify to the verifications. However, the independent certified audits required to be submitted must be performed in compliance with section 1923(j) and implementing regulations as a condition for receiving Federal payments under section 1903(a)(1) and 1923 of the Act.

5. **If DSH payments are based on hospital-specific DSH limits from prior year audits, recoupments and DSH payment redistribution might be necessary on an annual basis. How does CMS expect States to deal with this cost and with the potential hardship to the hospitals?**

This regulation does not require States to implement retrospective DSH payment methodologies or otherwise change the basic approach to DSH payment used by the States. Nor does it require delay in making DSH payments consistent with the authority of the approved Medicaid State plan. CMS recognizes that States may need to estimate uncompensated care to determine DSH payments in an upcoming Medicaid State plan rate year, indeed, this is currently the way most States distribute DSH payments. The regulation is intended to ensure that those estimates do not exceed the actual hospital-specific limit in the year in which the payments are received.

States retain considerable flexibility in setting DSH State plan payment methodologies to the extent that such methodologies are consistent with 1923(c) and all other applicable statute and regulations. This regulation provided for time frames that should provide States with accurate information with which to determine prospective DSH payments and time to review and adjust rates once actual eligible uncompensated care amounts are determined. States will have to determine how to best ensure that prospective DSH methodologies do not result in payments that exceed hospital-specific DSH limits, either by revising those methodologies or by providing for reconciliation of prospective payments with those limits. Because FFP is only available for DSH payments that do not exceed the hospital-specific limit, some States may determine that a retrospective DSH payment methodology or a DSH reconciliation is a reasonable way to manage its DSH allotment.

CMS as always is available to offer technical assistance to States in developing such methodologies. Additionally, CMS included a transition period in the regulation to ensure that States may adjust prospective estimates to avoid any immediate adverse fiscal impact.

6. **The final regulation requires a determination of whether or not the State made DSH payments that exceeded the hospital-specific DSH limit for any hospital in the Medicaid State plan rate year under audit. If the DSH audit identifies DSH payments made to a hospital in excess of the hospital-specific DSH limit, how should States treat such payments if the hospitals are no longer eligible for DSH, are bankrupt, or no longer exist?**

As stated in the final rule, beginning in Medicaid State plan rate year 2011, to the extent that audit findings demonstrate that DSH payments made in that year exceed the documented hospital-specific cost limits, CMS will regard them as representing discovery of overpayments to providers that, pursuant to 42 CFR Part 433, Subpart F, triggers the return of the Federal share to the Federal government (unless the DSH payments are redistributed by the State to other qualifying hospitals as an integral part of the audit process). This is not a “penalty” but instead reflects adjustment of an overpayment that was not consistent with Federal statutory limits. However, we note that, to the extent that States wish to redistribute any DSH payments that exceeded a particular hospital-specific limit, the Federally approved Medicaid State plan must reflect that payment policy and allow for individual payment adjustments based on the audit. Further, States need not refund the Federal share of overpayments made to providers who are determined to be bankrupt or out of business in accordance with 42 CFR 433.318.

7. **To meet the reporting and auditing requirement, States must perform audits associated with defined periods of time and must identify the actual costs incurred and payments received during that defined time period. Can a State use adjudicated claims date, or must**

they change to admission or discharge date, which is reflected in the comment and response of the DSH final rule?

Section 1923(g) of the Social Security Act imposes a limit that is based in part on a year's worth of services. The preamble language is merely illustrative of two approaches some States may already use to determine the volume of Medicaid services and payments to be included in the yearly limit and was not intend to be all inclusive. Adjudicated claims date would be another acceptable approach to determine the amount of services furnished during the year. However, the approach used must be consistent with the approved State plan language for the specified time period and should be clearly defined in the audit report.

8. **What does the final rule mean by the term Medicaid State plan rate year?**

In using the term State plan rate year, we recognize that while many States may set rates on a State fiscal year basis, some States set rates on a calendar or other annual basis and establish DSH limits accordingly. The State plan rate year is therefore the 12-month period defined by a State's approved State plan in which the State estimates eligible uncompensated care costs and determines corresponding DSH payments as well as other Medicaid payment rates.

9. **Some States utilize certified public expenditures (CPE) to finance the non-Federal share of DSH payments made up to hospital-specific DSH limits. Should States modify existing State plan provisions and/or special terms and conditions (STC) of section 1115 demonstrations in instances where the approved State plan and/or STCs methods for calculating costs for these CPE-funded payments differ from the method for calculating the hospital-specific limit required by the final regulation and associated DSH General Auditing and Reporting Protocol?**

To ensure that claims for DSH expenditures do not exceed hospital-specific DSH limits, States should modify their methods for calculating CPE-funded DSH payments to the extent that the approved State plan and/or STCs methods vary from that required by the final DSH audit regulation and associated DSH General Auditing and Reporting Protocol. If this requires a modification to the State plan or 1115 STCs, State should submit a State plan amendment or section 1115 demonstration amendment, respectively. The final regulation does include a transition period to ensure that States may adjust uncompensated care estimates prospectively to avoid any immediate adverse fiscal impact and to assist States in ensuring that future DSH payments do not exceed the hospital-specific DSH limit. Additionally, to permit States an opportunity to develop and refine audit procedures, audit findings from Medicaid State plan rate year 2005-2010 will be limited to use for the purpose of estimating prospective hospital-specific uncompensated care cost limits in order to make actual DSH payments in the upcoming Medicaid State plan rate years. CMS is not requiring retroactive collection for Medicaid State plan rate years that have already passed. By using that time to improve State DSH payment methodologies, States may avoid circumstances in which DSH payments that exceed Federal statutory limits must be recouped from hospitals.

Audit Reports

10. Please provide clarification on the extent to which the State may rely upon hospitals to perform the DSH audit. Please clarify whether the State may rely upon hospitals' current or expanded financial audits for the certification of the hospital-specific DSH limits.

As stated in the final rule, the responsibility for certification of an independent audit rests with the State. States must engage an independent auditor to certify that the requirements of the Federal regulation are satisfied, to provide an opinion for each specified verification, and to make a determination as to whether any DSH payments exceeded any hospital's specific DSH limit. States would not meet the independent audit certification requirement by merely expanding audits of hospital financial statements to obtain audit certification from each hospital. However, States may utilize an independent auditor to independently analyze and certify information submitted by each hospital to the State.

Furthermore, the mere fact that a specific auditing entity completes a Medicaid financial audit for a hospital does not necessarily preclude the State from contracting with that auditing entity to complete the independent DSH audit. To the extent that the auditor attests in the DSH audit report that they meet the requirements for auditor independence described in Chapter 3 of the General Accounting Organizations General Audit Standards (GAGAS), an auditing entity of any hospital's financial audit may be eligible to complete the certified DSH audit for the State.

11. Please provide guidance on what auditing standards and procedures should be used in undertaking the DSH audit as well as what type of report auditors should issue.

The purpose of the DSH audit is to ensure that Medicaid DSH payments comply with Federal statutory limits. The DSH audit will necessarily rely upon financial and cost report data that are subject to generally accepted accounting principles, and accounting principles specific to hospital accounting under federal grant programs.

Audit procedures that are in accordance with applicable industry standards would meet the criteria established within the final rule if the auditors certify the audit in accordance with the definition of "independent certified audit" as defined at 455.301 of the final rule. We understand that the term "certification" may have specific meaning within the auditing profession. Our use of the term "certification" for purposes of DSH audits is limited to the actions set forth at 455.301. For this purpose, certification means that the auditor attests to qualifying as an independent auditor, has reviewed the criteria of the Federal audit regulation and has completed the verification, calculations, and report under professional rules and generally accepted standards of audit practice. To the extent that the auditor decides that specific methods (which may include requirements beyond the scope of those specifically outlined within the regulation and protocol) are necessary to certify to the audit in accordance with the certification criteria at 455.301 and 455.304, then the auditor should employ these methods. As noted in 455.301, the certification should identify any data issues or other caveats that the auditor identifies as impacting the results of the audit.

We look forward to working with States in refining the auditing process throughout the transition period. Once States and CMS gain greater experience with the auditing process, CMS will work further with States to highlight best practices and auditing methods.

12. The 2005 and 2006 DSH audit reports are to be completed by September 30, 2009, and must be submitted to CMS by December 31, 2009. Are States able to grant extensions to auditors to complete the audits subsequent to September 30, if the final report is still delivered to CMS by December 31, 2009?

CMS has determined that it will apply a flexible enforcement strategy designed to ensure that States have sufficient time to properly implement the new requirements without undue hardship. Thus, CMS will not find a State to be out of compliance with the DSH reporting and auditing requirements for the initial (2005 and 2006) Medicaid State plan rate years until December 31, 2010. We do not anticipate any further delay of compliance enforcement, or any delay of compliance enforcement for subsequent audit years.

Even though CMS will be delaying compliance enforcement, CMS expects that States will be making good faith efforts to comply with the new requirements. We asked each State to identify, and to provide in writing to its respective CMS Associate Regional Administrator, a contact individual by September 30, 2009 to brief CMS representatives on the State's compliance status and progress. Based on those discussions, some States were/may be asked for detailed information about compliance efforts.

The final rule included a transition period recognizing that auditing processes and techniques may need to be refined. This transition period lasts through Medicaid State plan rate year 2010, before audit results will be given weight other than in making prospective estimates of hospital costs for the purposes of ongoing DSH payments. In the transition, CMS will work with States that make a good faith effort to fulfill all of the DSH reporting and auditing requirements and that also submit a final report to CMS by the December 31 deadline. It should be noted that States will still be expected to make DSH payments that conform to the hospital-specific limits beginning in 2011.

13. The rule states that the 2005 and 2006 DSH audit reports are to be submitted to CMS by December 31, 2009. What method will CMS use to determine submission date?

CMS has determined that it will apply a flexible enforcement strategy designed to ensure that States have sufficient time to properly implement the new requirements without undue hardship. CMS will not find a State to be out of compliance with the DSH reporting and auditing requirements for the initial (2005 and 2006) Medicaid State plan rate years until December 31, 2010. We do not anticipate any further delay of compliance enforcement, or any delay of compliance enforcement for subsequent audit years. We asked each State to identify, and to provide in writing to its respective CMS Associate Regional Administrator, a contact individual by September 30, 2009 to brief CMS representatives on the State's compliance status and progress. Based on those discussions, some States were/may be asked for detailed information about compliance efforts.

When States have completed the DSH audits and reports, they should submit the required reports and audits electronically via email to the Associate Regional Administrator of their respective CMS Regional Office on or before the applicable deadline. States are encouraged to carbon copy their Regional Office National Institutional Reimbursement Team (NIRT) representative and CMS Regional Office State representative as well. The receipt date will be the email creation and submission date as indicated on the email.

Certified audits should be submitted in a PDF format using an Adobe Acrobat application and should contain a PDF file of the completed reporting element template. All audit files should be submitted in zip data compression formats to ensure ease of electronic delivery.

CMS is exploring the possibility of including the required reporting elements into the MBES process and will provide additional guidance in the near future. Absent the MBES reporting process, States should submit the report as an excel spreadsheet in addition to the PDF format included in the certified audit report.

14. **Is CMS planning on setting a DSH payment threshold below which some or all of the reporting requirements will be waived?**

There is no statutory authorization for an exception to audit and reporting requirements with respect to hospitals that receive DSH payments. The audit and reporting requirements under section 1923(j) of the Act apply to all States that make DSH payments, with respect to each hospital receiving a DSH payment. As we noted in the preamble to the final rule, the statute requires that each State report to CMS data, and submit a certified audit, that verifies that all hospitals receiving DSH payments under the Medicaid State plan actually qualify to receive such payments and that such payments do not exceed the hospital-specific DSH limit. Even if a State only makes DSH payments under its approved Medicaid State plan that relate to the uncompensated care of providing inpatient and outpatient hospital services to Medicaid individuals (that is, Medicaid shortfall), it would be possible for payments to a hospital to exceed the hospital-specific limit if the hospital had a surplus in furnishing hospital services to the uninsured. While this may be an unlikely circumstance, we cannot at this time be certain that it never occurs. Therefore, in such a circumstance we will accept reporting limited to Medicaid uncompensated care only when the hospital provides a certification that it incurred additional uncompensated care costs serving uninsured individuals. When we review certified audit reports submitted by States, we will consider whether more flexibility would be warranted, and we may address the issue in future reporting instructions. However, prior to receiving the first set of annual State reports, CMS is not contemplating any changes to the reporting requirements.

Auditor Independence

15. What constitutes an independent auditor?

Medicaid regulations at 42 CFR 455.301 define a certified independent audit in part to mean an audit that is conducted by an auditor that operates independently from the Medicaid agency or subject hospital. The intent is for the auditor to be fully able to render objective and impartial judgment on all matters relating to a required DSH audit. Examples of potential conflicts for audit entities would be: calculating a State's DSH payments under the Medicaid State plan; developing State plan DSH payment methodologies for States; preparing uninsured/Medicaid source documents and/or originating data relating to the DSH program on behalf of subject hospitals and/or the State; serving as auditor to any subject hospital or the State agency; and possessing a direct or indirect financial interest in the State's DSH program. In this context, independence generally means that the audit organization and individual auditor is free of any impairment that may in fact or in appearance preclude an impartial opinion or reporting.

States are responsible for ensuring that no possible impairment exists between the auditing organization/auditors and the Medicaid agency and/or hospital. Within the auditing profession, standards have developed to help guide auditors and/or their clients with respect to independence and impairments that might potentially compromise it. The final rule provides that these principles are to be applied to Medicaid DSH audits. The General Accountability Office (GAO), in Chapter 3 of its most recent revision to Government Auditing Standard, identifies specific criteria for independence and outlines impairments to independence in government auditing practices (http://www.gao.gov/govaud/govaudhtml/index.html).

While we believe these generally accepted standards relating to independence in government auditing to be well understood by the auditing profession and would expect their correct application to the required audits, there are some situations that may warrant additional review. For instance, section 3.29 of the General Standards outlines non-audit services that impair auditor independence. The section states certain non-audit services directly support an entity's operations and impair an audit organization's ability to meet overarching audit principles (in this case we would consider the "entity" to be the Medicaid agency and/or hospital). Some examples of these types of services that may impair independence for purposes of conducting the DSH audit include:

a. maintaining or preparing the audited entity's basic accounting records or maintaining or taking responsibility for basic financial or other records that the audit organization will audit;
b. posting transactions (whether coded or not coded) to the entity's financial records or to other records that subsequently provide input to the entity's financial records;
c. determining account balances or determining capitalization criteria;
d. designing, developing, installing, or operating the entity's accounting system or other information systems that are material or significant to the subject matter of the audit;
e. providing payroll services that (1) are material to the subject matter of the audit or the audit objectives, and/or (2) involve making management decisions;
f. providing appraisal or valuation services that exceed the scope described in paragraph 3.28 c;
g. recommending a single individual for a specific position that is key to the entity or program under audit, otherwise ranking or influencing management's selection of the candidate, or conducting an executive search or a recruiting program for the audited entity;
h. developing an entity's performance measurement system when that system is material or significant to the subject matter of the audit;
i. developing an entity's policies, procedures, and internal controls;
j. performing management's assessment of internal controls when those controls are significant to the subject matter of the audit;
k. providing services that are intended to be used as management's primary basis for making decisions that are significant to the subject matter under audit;
l. carrying out internal audit functions, when performed by external auditors; and
m. serving as voting members of an entity's management committee or board of directors, making policy decisions that affect future direction and operation of an entity's programs, supervising entity employees, developing programmatic policy, authorizing an entity's transactions, or maintaining custody of an entity's assets.

Further examples of such potential conflicts for audit entities would be: providing audit services for the Medicaid program generally (not specifically related to DSH payments) such as auditing cost reports or determining Medicaid service rates; serving as auditor to any subject hospital or the State agency; and possessing a direct or indirect financial interest in the State's Medicaid program.

There are situations in which sufficient firewalls exist between such services that would serve to eliminate the potential conflict regarding auditor independence. In such cases, States must explain why such an audit firm meets the GAGAS independence standards despite the appearance that the auditing entity is not independent. The audit firm must also declare its independence in the audit and report submitted to CMS. States should look to the General Auditing Standards in their entirety to ensure that no possible impairments to independence exist.

For State plan rate year 2007 and thereafter, auditing organizations/auditors must submit a signed statement declaring independence of the respective Medicaid agency and hospitals. This statement should be included with the audit and report submitted to CMS on an annual basis.

16. Can States use provider-related donations, assessments, taxes on, or other similar funding arrangements with DSH hospitals to fund the required audits?

The DSH audit requirements and final rule do not supersede any Medicaid provisions relating to donations and taxes. As a practical matter, we do not see how a State could rely on "voluntary" donations to fund required Medicaid programs and expenses. As indicated in the preamble, section 1923(j) makes these DSH audit and reports a Medicaid program requirement and as such States are responsible for funding the costs to fulfill them just as they are any other Medicaid administrative costs. To the extent a State's payment methodology for the audits and reports would be prohibited as an impermissible tax or donation, a State may not employ that methodology for purposes of funding the audits. States may not impose DSH fees or require financial participation in the funding of the audit as a condition for receiving DSH payments. Furthermore, to the extent that a provider-related donation presumed to be bona fide contains a hold harmless provision, it would not be considered a bona fide donation.

Revenue Recognition

17. How should States, hospitals, and auditors treat Medicaid payments received after the completion of the audit for a particular Medicaid State plan rate year?

In recognition of potential delays in obtaining needed information, we have extended the period for ongoing report and audit submission until the end of the Federal fiscal year that is at least three years after the close of the Medicaid State plan rate year. We believe that hospitals would have received most Medicaid, DSH payments, and other payments associated with that Medicaid State plan rate year.

Based on the modifications to the audit and reporting deadlines, the existing requirement at 42 CFR 447.45(d) for provider claims to be filed within a year from the date of service and promptly paid by the State, and the existing two-year timely claim filing requirement at 45 CFR 95.7, there should not be a significant adjustment to Medicaid payments that would warrant a corrected audit and report. To the extent that a significant adjustment to Medicaid payments occurs and States claim Federal matching dollars (or return Federal matching dollars) as a prior period adjustment, States should correct the audit and report by indicating post-audit adjustments to Medicaid and DSH payments (or uncompensated care costs if Medicaid payment adjustments affect the Medicaid shortfall). When post-audit retroactive adjustments to Medicaid payments are not significant, the payments should be measured during the audit of the Medicaid State plan rate year in which the revenues are received.

18. **The final regulation and the preamble address which State plan rate year revenues apply to for purposes of calculating a hospital-specific DSH limits. It appears, however, that the preamble requires Medicaid payment offsets occurring after the completion of the DSH audit be applied duplicately in calculating hospital-specific DSH limits for two distinct State plan rate years. Can you confirm that these Medicaid revenues should be applied in calculating hospital-specific DSH limits for only one Medicaid State plan rate year?**

Medicaid revenues identified in the post-audit period must only be applied against one State plan rate year for purposes of calculating hospital-specific DSH limits.

19. **Against which Medicaid State plan rate year are revenues received by a hospital by or on behalf of either 'self-pay' or uninsured individuals during the Medicaid State plan rate year under audit offset?**

The General DSH Audit and Reporting Protocol provides clarification regarding all payments received during cost reporting period(s) covering the Medicaid State plan rate year under audit by or on behalf of patients with no source of third party coverage. There will be no attempt to allocate payments received during the State plan rate year to services provided in prior periods. Since the goal of the audit is to determine uncompensated DSH costs in a given Medicaid State plan rate year, all payments received in the year will be counted as revenue to the hospital in that same year. It is 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 are not counted as revenue until actually received.

Allowable Costs/Medical Necessity

20. **Will CMS be issuing guidance on what constitutes medically necessary services?**

CMS does not intend to issue guidance on what constitutes medically necessary services. CMS will continue to allow States flexibility in determining medical necessity under their individual Medicaid programs within the guidelines of the Social Security Act provided at 1902(a)(30) and 1902(a)(19), and the implementing regulations at 42 CFR 440.230(d), which state "The [Medicaid] agency may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures." Generally, services that are considered reimbursable under the Medicaid State plan would also be considered as necessary services when calculating a hospital's eligible uncompensated care cost.

21. **Are States required to follow only Medicare reasonable cost principles, or will they be allowed to establish allowable cost rules that may differ from Medicare?**

As noted in the preamble to the final rule, section 1923(g)(1) of the Act provides for a Federal limitation based on costs that must be calculated in accordance with Federal accounting standards. The same

methods used in preparing the Medicare 2552-96 cost report should be applied in determining costs to be used in calculating the hospital-specific DSH limits.

Hospitals' Medicare cost reports, audited financial statements, and accounting records should contain the information necessary for reporting and auditing responsibilities, in combination with information provided by the States' Medicaid Management Information Systems (MMIS) and the approved Medicaid State plan governing the Medicaid payments made during the audit period. The CMS developed General DSH Audit and Reporting Protocol will assist States and auditors in using information from each of these sources to determine allowable uncompensated care costs consistent with the statutory requirements. The protocol is available on the CMS Web site at: www.cms.hhs.gov/MedicaidGenInfo/Downloads/CMS2198FRptProtocol.pdf.

22. **If a State allows for graduate medical education as an allowable component of cost and is included in the Medicaid State Plan, should the State require the filing of Medicaid cost reports that incorporate the graduation medical education in the determination of program cost?**

All costs that are associated with services that are defined and reimbursed under the approved Medicaid State plan as inpatient hospital services and outpatient hospital services to Medicaid eligible individuals and to individuals with no source of third party coverage may be included in calculating the hospital-specific DSH limit. To properly capture these costs in the hospital-specific DSH limit, State's should include these costs as part of the Medicare 2552-96 cost report step-down process and utilize the General DSH Audit and Reporting Protocol.

To the extent that a State allows graduate medical education (GME) as a component of cost and it is reimbursed under the Medicaid State plan, the State can include these costs in determining hospital-specific DSH limits. Please be reminded that the State still must use the cost reporting and apportionment process as prescribed by the Medicare 2552-96 identified in the General DSH Audit and Reporting Protocol.

23. **"How should States treat unpaid Medicaid days or charges for purposes of calculating hospital-specific DSH limits?" What if the unpaid days are a result of untimely filing or a hospitals failure to seek prior authorization?**

The hospital-specific DSH limit includes the costs incurred during the year of furnishing hospital services to Medicaid beneficiaries and the uninsured, net of Medicaid payments and payments made by or on behalf of the uninsured. To be included as Medicaid cost in the limit, a hospital service must be included in a State's definition of an inpatient hospital service or outpatient hospital service under the approved State plan and furnished to Medicaid eligible individuals.

Individuals with Medicaid or other third party coverage are not considered as uninsured under 1923(g)(1). Improper billing by a provider does not change the status of an individual as insured or otherwise covered. In no instance should costs associated with claims denied by a health insurance carrier for such a reason be included in the calculation of hospital-specific uncompensated care costs.

24. A Medicaid program in a State covers speech therapy services for beneficiaries under 18 years of age. A hospital in that State provided speech therapy to a Medicaid enrollee who was over 18 and claimed the services as uninsured care. Are the costs incurred by the hospital in providing the speech therapy service allowed to be included in the calculation of hospital-specific DSH limits?

In this example the costs associated with speech therapy services can be included in the calculation of hospital-specific DSH limits to the extent that such services are treated as "hospital services" under the State plan because the patient is eligible for Medicaid. The hospital-specific limit is based on the costs incurred for furnishing ``hospital services" and does not include costs incurred for services that are outside either the State or Federal definition of inpatient or outpatient hospital services. While States have some flexibility to define the scope of ``hospital services," States must use consistent definitions of ``hospital services." Hospitals may engage in any number of activities, or may furnish practitioner or other services to patients, that are not within the scope of ``hospital services," including speech therapy. A State cannot include in calculating the hospital-specific DSH limit cost of services that are not defined under its Medicaid State plan as a Medicaid inpatient or outpatient hospital service.

Determination of Uninsured Status

25. CMS seems to contradict itself in replying to the question of including patients who lack coverage for the service provided but not necessarily any coverage at all. CMS states that they have never read the statute to be service-specific and believe that such an interpretation would be inconsistent with the broad statutory references to insurance or other coverage. Furthermore, CMS replies that such a reading would result in cost shifting from private sector coverage to the Medicaid program. However, in a January 10, 1995 letter to Donna Checkett, Chair of the State Medicaid Director's Association, CMS clarified 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". Is it CMS's position now that it depends on whether the individual has creditable coverage consistent with 45 CFR 144 and 146 and not whether the specific service is covered?

Section 1923(g)(1) of the Act refers to the costs of hospital services furnished by the hospital to individuals who have no health insurance (or other source of third party coverage). This language is not service-specific and any interpretation to the contrary would be inconsistent with the broad statutory references to insurance or other coverage. In an effort to adhere to a more accurate representation of the broad statutory references to insurance or other coverage; and to delineate more definitively the meaning of the term uninsured, CMS clarified the populations for which hospitals may calculate uncompensated care costs. We interpret the phrase ''who have health insurance (or other third party coverage)'' to broadly refer 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. Creditable coverage would include coverage of an individual under a group health plan, Medicare, Medicaid, a medical care program of the IHS or tribal organization, and other examples as outlined in the rules relating to creditable coverage at 45 CFR 146.113.

26. Does an advance beneficiary notice for a medically necessary procedure satisfy the requirement that "[c]laims denied by a health insurance carrier, including a Medicaid contracted managed care organization, for any reason other than the inpatient/outpatient service or services provided were not covered services within the individuals health benefit package are furnished to individuals who have health insurance coverage"?

The quoted sentence is taken out of context and does not reflect a "requirement." The underlying requirement is that, to be included in the calculation of the hospital-specific limit, the services at issue must be furnished to an individual who does not have "health insurance (or other source of third party coverage)." As indicated in the sentence prior to the quoted sentence. "[t]he costs of services for individuals who have health insurance are not included in calculating the hospital-specific limit, even if insurance claims for that particular service are denied for any reason." And the following sentence states that services are considered to have been provided for an individual with health insurance or third party coverage even though a claim has been "denied due to improper billing, lack of preauthorization, lack of medical necessity, or non-coverage under the third party insurance package." While the quoted sentence may have been inartfully drafted, the overall meaning is clear. The quoted sentence does not indicate that costs related to denials for non-coverage automatically qualify for inclusion in the hospital-specific limit; it simply indicates that certain denied claims cannot be included in the cost limit. When a claim is denied as non-covered, the hospital may then wish to verify that the individual was actually insured, and that the insurance was creditable coverage. Both the statute and the rule clearly indicate that costs of services for individuals who have health insurance (or other source of third party coverage) are not included in calculating the hospital-specific limit, even if insurance claims for that particular service are denied for any reason.

27. The preamble states, "To the extent the Medicaid payment does not fully cover the cost of the inpatient or outpatient hospital services provided, the unreimbursed costs of those services would be counted in calculating that limit." Some hospitals have interpreted this language to mean that any services provided to Medicaid beneficiaries but not reimbursed by Medicaid should be treated as uninsured. Is this interpretation correct?

The interpretation referenced in the question does not accurately reflect the provisions at section 1923(g)(1) of the statute which expressly refers to uncompensated costs of furnishing hospital services to individuals eligible for Medicaid or individuals who have no health insurance or other third party coverage. If an individual is Medicaid eligible on the day they received medically necessary inpatient or outpatient hospital services, then those services (to the extent that they are allowable under the State's plan) would be included in calculating the Medicaid portion of the hospital-specific limit.

28. How should States count costs not otherwise covered for individuals in an IMD (as Medicaid shortfall, uncompensated care costs, or not included) for those individuals with Medicaid ages 22-64 while in an IMD if the individual is also a dual eligible (Medicare)?

For the costs of services provided to those patients between the ages of 22 and 64 who are otherwise eligible for Medicaid, the treatment of the service costs in the hospital-specific limit may vary based on State practice. Many States remove these individuals from eligibility rolls for administrative convenience (and must reinstate them if they are discharged from the IMD); if so, the costs should be reported as uncompensated care for the uninsured. States that do not remove the individuals from the Medicaid

eligibility rolls should report the costs as uncompensated care for the Medicaid population. Therefore, the costs of services provided in an IMD to an individual who is 22-64 and who is otherwise Medicaid eligible, can be included either as uninsured uncompensated or Medicaid uncompensated in the UCC, depending on the eligibility status (as determined by the state) of the individual while in the IMD.

For dual eligible patients ages 22-64 old in an IMD, the treatment of costs would be determined by the State Medicaid eligibility policies. In States that do not remove the individual from Medicaid eligibility, these dual eligibles are Medicaid eligible and their uncompensated costs should be included as Medicaid uncompensated costs. In States that remove such individuals from Medicaid eligibility rolls while in an IMD, these individuals would be Medicare only during the IMD stay and therefore considered to have third party coverage (Medicare). Uncompensated care costs would therefore not be allowed in the uninsured uncompensated cost portion.

Hospital Data

29. Because hospitals may not have detailed cost center-specific charge information for uninsured and Medicaid MCO patients for prior years, would it be acceptable to allocate total uninsured or Medicaid MCO charges to specific ancillary cost centers based on the percent to total of Medicaid charges, or, should uninsured or Medicaid MCO costs be disallowed entirely for these hospitals?

We expect that State reports and audits will be based on the best available information in conjunction with guidance from their independent auditors. If audited Medicare cost reports are not available for each hospital, the DSH report and audit may need to be based on Medicare cost reports as filed. We note that hospitals must follow the cost reporting and apportionment process as prescribed by the Medicare 2552-96 cost report process. To the extent that these cost reports do not contain the precise information needed for the DSH calculation, it may be necessary for hospitals to modify their accounting techniques. In those circumstances, for the initial audits, it will be necessary to use other source materials such as audited hospital financial records and other records, and to develop methodologies to determine the necessary information from such records. We expect States, independent auditors and hospitals to work cooperatively to develop such methodologies.

CMS has developed a General DSH Audit and Reporting Protocol which will be available on the CMS Web site that should assist States and auditors in utilizing information from each source identified above and developing methods to determine uncompensated costs of furnishing hospital services to the Medicaid and uninsured populations. The protocol is available on the CMS Web site at: www.cms.hhs.gov/MedicaidGenInfo/Downloads/CMS2198FRptProtocol.pdf.

30. The regulation requires use of a Medicare hospital cost report to provide data to States and CMS. Some children's hospitals do not care for a large number of Medicare patients and may not file Medicare cost reports or may provide low utilization reports. Is there an alternative reporting tool that children's hospitals could use and still be in compliance with the regulation provisions?

We anticipate that States and auditors will use the best available and most accurate data. The DSH reports and audit will rely on existing financial and cost reporting tools including the Medicare 2552–96 cost report as well as audited hospital financial statements and accounting records in combination with information provided by the States' Medicaid Management Information Systems (MMIS) and the approved Medicaid State plan governing the Medicaid payments made during the audit period. If a hospital (e.g. a children's hospital) does not file or files only a partial Medicare 2552-96 cost report, the State remains responsible for reporting the information which would have otherwise been available on the Medicare 2552-96 from each hospital for Medicaid and uninsured purposes. In order to fulfill the requirements of this section, States may require such hospitals to provide the same data to the State as if they were filing the Medicare 2552-96.

31. When you say "costs of services" or "costs for dual eligibles" do you mean that this term is interchangeable with charges or do you mean just costs?

A. In the regulation, the term "costs" is not interchangeable with the term "charges."

32. As part of the reporting requirements, is the State required to submit a LIUR calculation for every hospital that received a DSH payment or only for the hospitals which are deemed eligible for disproportionate share based on their LIUR?

Under section 1923(b), hospitals may be deemed as disproportionate share hospitals based on either their MIUR or LIUR. We recognize that some hospitals may be so deemed based on both their MIUR and their LIUR. In order to fulfill the requirements of the final rule, States should submit the appropriate calculation for both the LIUR and the MIUR for these hospitals. We believe this is beneficial to both the State and to hospitals. The report must show that each hospital receiving DSH payments meets applicable DSH eligibility requirements. Should a hospital thought to be qualified under the LIUR but is later found not to be, a determination can readily be made about its potential DSH eligibility under the other formula.

Dual Eligibility

33. Would days, costs, and revenues associated with patients that have both Medicaid and private insurance coverage (such as Blue Cross) also be included in the calculation of the MIUR percentage and the DSH limit in the same way States include days, costs and revenues associated with individuals dually eligible for Medicaid and Medicare?

Days, cost, and revenues associated with patients that are dually eligible for Medicaid and private insurance should be included in the calculation of the Medicaid inpatient utilization rate (MIUR) for the purposes of determining a hospital eligible to receive DSH payments. Section 1923(g)(1) does not contain an exclusion for individuals eligible for Medicaid and also enrolled in private health insurance. Therefore, days, costs, and revenues associated with patients that are eligible for Medicaid and also have private insurance should be included in the calculation of the hospital-specific DSH limit. As Medicaid should be the payer of last resort, hospitals should also offset both Medicaid and third-party

revenue associated with the Medicaid eligible day against the costs for that day to determine any uncompensated amount.

34. The regulation states that costs for dual eligibles should be included in uncompensated care costs. Could you please explain further? Under what circumstances should we include Medicare payments?

Section 1923(g) of the Act defines hospital-specific limits on FFP for Medicaid DSH payments. Under the hospital-specific limits, a hospital's DSH payment must not exceed the costs incurred by that hospital in furnishing services during the year to Medicaid and uninsured patients less payments received for those patients. There is no exclusion in section 1923(g)(1) for costs for, and payment made, on behalf of individuals dually eligible for Medicare and Medicaid. Hospitals that include dually-eligible days to determine DSH qualification must also include the costs attributable to dual eligibles when calculating the uncompensated costs of serving Medicaid eligible individuals. Hospitals must also take into account payment made on behalf of the individual, including all Medicare and Medicaid payments made on behalf of dual eligibles. In calculating the Medicare payment for service, the hospital would have to include the Medicare DSH adjustment and any other Medicare payments (including, but not limited to Medicare IME and GME) with respect to that service. This would include payments for Medicare allowable bad debt attributable to dual eligibles.

35. Is it CMS' intention that dual eligibles would include individuals with Medicare for whom Medicaid pays only Medicare deductibles, coinsurance, or Medicare Part A or B premiums?

For the purposes of the DSH audits and reporting requirements, dual eligibles include all individuals with Medicare who also are eligible for some form of Medicaid benefit. This includes those individuals for whom Medicaid pays only Medicare deductibles, coinsurance, or Medicare Part A or B premiums.

36. Medicare DSH allows hospitals to claim additional Medicaid days beyond the paid days for patients with commercial insurance through their employer and Medicaid. Would these patients be included in Medicaid DSH since they are Medicaid eligible?

The Medicare DSH program and the Medicaid DSH program are separate programs authorized by different sections of the statute and with different purposes and goals. If the patients are Medicaid eligible, then costs and revenues associated with inpatient and/or outpatient services furnished to them must be included in the hospital-specific limit calculation. Revenues required to be offset against a hospital's DSH limit would include any amounts received by the hospital by or on behalf of the Medicaid eligible individuals (for any days those individuals remain Medicaid eligible) during the Medicaid State plan rate year under audit (except payments from State or local programs based on indigency).

ARRA

37. How is the DSH audit and reporting rule affected by section 5002 of the American Recovery and Reinvestment Act of 2009 (ARRA)?

DSH payment adjustments made using the ARRA increased state allotments are subject to DSH audit and reporting requirements. ARRA provided additional potential fiscal relief to States by increasing most States' Federal fiscal year (FFY) 2009 and 2010 Medicaid DSH allotments by 2.5 percent. Specifically, section 5002 of ARRA amended section 1923(f)(3) of the Act to provide a temporary increase in state DSH allotments for these fiscal years. Section 5002 of ARRA did not otherwise modify DSH requirements. States are required to follow the same requirements for payment adjustments made under the increased allotment as they would for any other DSH payment adjustments, including DSH reporting and auditing requirements.

Exhibit A:

All inclusive, firm fixed price for each audit period:

SFY 2010 (July 1, 2009 – June 30, 2010)

				Total Cost for Audit Period SFY10
Total Cost SFY10 Audit				(A_1)

Additional Services	**Hourly Rate**	**Hours**	**Total Cost for Audit Period SFY10 (Hourly Rate * 100)**
Additional Services		100	(A_2)

Estimated Grand Total Not to Exceed Cost (A_1+A_2)	(A)

Optional Renewal Periods:

SFY 2011 (July 1, 2010 – June 30, 2011)

				Total Cost for Audit Period SFY11
Total Cost SFY11 Audit				(B_1)

Additional Services	**Hourly Rate**	**Hours**	**Total Cost for Audit Period SFY11 (Hourly Rate * 100)**
Additional Services		100	(B_2)

Estimated Grand Total Not to Exceed Cost (B_1+B_2)	(B)

SFY 2012 (July 1, 2011 – June 30, 2012)

				Total Cost for Audit Period SFY12
Total Cost SFY12 Audit				(C_1)

Additional Services	**Hourly Rate**	**Hours**	**Total Cost for Audit Period SFY12 (Hourly Rate * 100)**
Additional Services		100	(C_2)

Estimated Grand Total Not to Exceed Cost (C_1+C_2)	(C)

Estimated Grand Total for Three (3) Year Contract Period (A+B+C) $ _____

Notes

1. The Vendors Estimated Grand Total Not to Exceed Cost will include all general and administrative staffing (secretarial, clerical, etc.), travel, supplies and other resource costs necessary to perform all services within the scope of this procurement.
2. The hours for Additional Services are estimated and are to be used for cost bid evaluation purposes only.
3. The cost bid proposal will be evaluated based on the Estimated Grand Total for the Three (3) year contract period.
4. The Vendor will invoice in arrears monthly. Payment will be issued in equal monthly increments during the contract period for each audit year, with the last payment withheld until a final audit report is delivered and accepted by the Bureau.
5. Additional services will be reimbursed based on an approved Statement of Work at the hourly rate bid.

_____
(Company)

_____
(Representative Name, Title)

_____
(Contact Phone/Fax Number)

_____
(Date)

If applicable, sign and submit the attached Resident Vendor Preference Certificate with the quotation.