DEPARTMENT OF AGRICULTURE

Forest Service

36 CFR Part 228

RIN 0596–AC20

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

43 CFR Part 3160

[W0–610–411H12–24 1A]

RIN 1004–AD59

Onshore Oil and Gas Operations; Federal and Indian Oil and Gas Leases; Onshore Oil and Gas Order Number 1, Approval of Operations

AGENCIES: U.S. Forest Service, Agriculture; Bureau of Land Management, Interior.

ACTION: Proposed rule; Notice of extension of public comment period.

SUMMARY: The Bureau of Land Management (BLM) and the U.S. Forest Service (FS) are extending by 60 days the public comment period for the proposed rule published in the **Federal Register** on July 27, 2005 (70 FR 43349). The proposed rule would revise existing Onshore Oil and Gas Order Number 1 (see 48 FR 48916 as amended at 48 FR 56226 (1983)). The Order provides the requirements necessary for the approval of all proposed oil and gas exploratory, development, or service wells on all Federal and Indian (except Osage Tribe) onshore oil and gas leases, including leases where the surface is managed by the FS. It also covers approvals necessary for subsequent well operations, including abandonment. In response to public requests for additional time and because the recently enacted Energy Policy Act of 2005 impacts certain provisions of the proposed rule, the BLM and the FS are extending the comment period 60 days from the original comment period closing date of August 26, 2005. The comment period is extended to October 25, 2005, to give the public additional time to comment.

DATES: Send your comments to the BLM on or before October 25, 2005. The BLM and the FS may not necessarily consider or include in the Administrative Record for the final rule comments that we receive after the close of the comment period or comments delivered to an address other than those listed below (see **ADDRESSES**).

ADDRESSES: Mail: Director (630), Bureau of Land Management, Eastern States Office, 7450 Boston Boulevard, Springfield, Virginia 22153. Hand Delivery: 1620 L Street, NW., Suite 401, Washington, DC 20036. E-mail: *comments_washington@blm.gov.* Federal eRulemaking Portal: *http://www.regulations.gov.*

FOR FURTHER INFORMATION CONTACT: James Burd at (202) 452–5017 or Ian Senio at (202) 452–5049 at the BLM or Barry Burkhardt at (801) 625–5157 at the FS. Persons who use a telecommunications device for the deaf (TDD) may contact these persons through the Federal Information Relay Service (FIRS) at 1–800–877–8339, 24 hours a day, 7 days a week.

SUPPLEMENTARY INFORMATION: The BLM and the FS published the proposed rule on July 27, 2005 (70 FR 43349), and provided a 30 day comment period that will end on August 26, 2005. We are extending the comment period on the proposed rule until October 25, 2005. The comment period is being extended as a result of requests for extension from the public, but also because the recently enacted Energy Policy Act of 2005 (Act) impacts certain provisions of the proposed rule having to do with timing of the Application for Permit to Drill or Deepen package (APD) approvals. To make the proposed rule consistent with the provisions in that Act, the BLM intends to publish a further proposed rule in the **Federal Register** in the near future amending provisions associated with the timing of APD approvals.

Dated: August 22, 2005.

Dale N. Bosworth,

Chief, USDA—Forest Service.

Dated: August 19, 2005.

Rebecca W. Watson,

Assistant Secretary of the Interior.

[FR Doc. 05–17051 Filed 8–25–05; 8:45 am]

BILLING CODE 4310–84–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 447 and 455

[CMS–2198–P]

RIN 0938–AN09

Medicaid Program; Disproportionate Share Hospital Payments

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

ACTION: Proposed rule.

SUMMARY: This proposed rule would implement section 1001(d) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) which establishes new reporting and auditing requirements for State Disproportionate Share Hospital payments.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on October 25, 2005.

ADDRESSES: In commenting, please refer to file code CMS–2198–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of three ways (no duplicates, please):

1. *Electronically.* You may submit electronic comments on specific issues in this regulation to *http://www.cms.hhs.gov/regulations/ecomments.* (Attachments should be in Microsoft Word, WordPerfect, or Excel; however, we prefer Microsoft Word).

2. *By mail.* You may mail written comments (one original and two copies) to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–2198–P, P.O. Box 8010, Baltimore, MD 21244–1850.

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

3. *By hand or courier.* If you prefer, you may deliver (by hand or courier) your written comments (one original and two copies) before the close of the comment period to one of the following addresses. If you intend to deliver your comments to the Baltimore address, please call telephone number (410) 786–9994 in advance to schedule your arrival with one of our staff members. Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201; or 7500 Security Boulevard, Baltimore, MD 21244–8010.

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

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

FOR FURTHER INFORMATION CONTACT: Jim Frizzera, (410) 786–9535.

SUPPLEMENTARY INFORMATION:

Submitting Comments: We welcome comments from the public on all issues set forth in this rule to assist us in fully considering issues and developing policies. You can assist us by referencing the file code **CMS–2198–P** and the specific ''issue identifier'' that precedes the section on which you choose to comment.

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. CMS posts all electronic comments received before the close of the comment period on its public Web site as soon as possible after they have been received. Hard copy comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1–800–743–3951.

I. Background

Title XIX of the Social Security Act (the Act) authorizes Federal grants to States for Medicaid programs that provide medical assistance to low-income families, the elderly, and persons with disabilities. Section 1902(a)(13)(A)(iv) of the Act requires that States make Medicaid payment adjustments for hospitals that serve a disproportionate number of low-income patients with special needs. Section 1923(a)(2)(D) of the Act requires States to provide an annual report to the Secretary describing the payment adjustments made to each disproportionate share hospital (DSH).

Section 1923 of the Act also sets out certain limits on Federal financial participation for State DSH payments. Section 1923(f) of the Act defines, for each State, an aggregate annual limit on Federal financial participation for DSH payments. Section 1923(g)(1) of the Act also defines hospital-specific limits on Federal financial participation for DSH payments. Under the hospital-specific limits, a hospital's DSH payments must 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'').

II. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003

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 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.

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.

III. Provisions of the Proposed Regulations

A. Reporting Requirements

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

Currently, under § 447.299, each State is required to report and maintain certain information about DSH program spending. Under § 447.299(a) and (b), each State is required to submit and report to CMS the quarterly aggregate amount of DSH payments. Each State is also required, under § 447.299(c), to maintain and make available upon request supporting documentation for the State's DSH program, including the amount of DSH payments to each individual hospital each quarter. Section 447.299(d) provides that future grant awards may be deferred or disallowed if a State fails to comply with these reporting requirements.

We are proposing to add a new paragraph (c) to the reporting requirements in § 447.299. We are proposing 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 are proposing that the following information reflects 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. Specifically, proposed 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 following information for each DSH hospital:

- Hospital Name.
- Medicare Provider Number.
- Medicaid Provider Number.
- Type of Hospital. The State would indicate if the hospital is an acute, long-term care, psychiatric, teaching, children's, rehabilitation, or other facility. If other facility, the State would be asked to specify the type.
- Type of Hospital Ownership. The State would indicate whether the hospital is a privately-owned, State government-owned, non-State government-owned, or a facility owned by the Indian Health Service, or a tribal government. The State would also

indicate whether the hospital is privately operated, State-government operated, non-State government operated, or a facility operated by the Indian Health Service, or a tribal government.

• Medicaid Inpatient Utilization Rate. The State would indicate the hospital's Medicaid inpatient utilization rate, as defined in section 1923(b)(2) of the Act.

• Low Income Utilization Rate. The State would indicate the hospital's low income utilization rate, as defined in section 1923(b)(3) of the Act. The low income utilization rate determination should only include those individuals that have no source of third party coverage for the inpatient hospital services they receive.

• DSH Payments. The State would indicate the total annual DSH payments made to the hospital. States need only report the single, aggregate annual amount of DSH payments made to the hospital, regardless of the number of separate DSH pools or the number of individual payments.

• Regular Medicaid Rate Payments. The State would indicate the total annual amount paid to the hospital by the State, not including any DSH payments or supplemental/enhanced payments, for inpatient hospital and outpatient hospital services furnished to Medicaid eligible individuals.

• Medicaid Managed Care Organization Payments. The State would indicate 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.

• Supplemental/Enhanced Medicaid Payments. The State would indicate the total annual amount of supplemental/enhanced Medicaid payments made to the hospital by the State for inpatient hospital and outpatient hospital services furnished to Medicaid eligible individuals. These amounts do not include DSH payments, regular Medicaid rate payments, and Medicaid managed care organization payments.

• Indigent Care Revenue. The State would indicate the total annual payments received by the hospital from individuals with no source of third party coverage for inpatient hospital and outpatient hospital services they receive.

• Transfers. The State would indicate the total annual amount of funds transferred by the hospital to the State or local governmental entity as a condition of the hospital receiving any Medicaid payment or DSH payment.

• Total Cost of Care. The State would indicate separately the total annual costs incurred for furnishing inpatient hospital and outpatient hospital services provided to Medicaid individuals and the total 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.

• Uncompensated Care Costs. The State would indicate separately the total annual amount of uncompensated care costs for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individuals and to individuals with no source of third party coverage for the inpatient hospital and outpatient services they receive. 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 inpatient hospital and outpatient hospital services they receive less the sum of regular Medicaid rate payments, Medicaid managed care organization payments, supplemental/enhanced Medicaid payments, and indigent care revenue). Uncompensated care costs do not include bad debt or payer discounts.

• Medicaid Eligible and Uninsured Individuals. The State would indicate the total annual unduplicated number of Medicaid eligible individuals receiving inpatient hospital and outpatient hospital services and the total annual unduplicated number of individuals with no source of third party coverage for the inpatient hospital and outpatient hospital services they receive.

Section 1011, Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens, of the MMA, requires that the Secretary directly pay hospitals and certain other providers for their otherwise un-reimbursed costs of providing services required by section 1867 of the Act (EMTALA) and related hospital inpatient, outpatient, and ambulance services furnished to undocumented aliens, aliens paroled into the United States at a U.S. port of entry for the purpose of receiving such services, and Mexican citizens permitted temporary entry to the U.S. with a laser visa. In addition, payment will be made from an allotment that varies by the number of undocumented aliens in each State. Provider payments are subject to a pro-rata reduction if the State allocation is insufficient to provide full reimbursement under the formula established by the Secretary.

In general, we believe that the receipt of a section 1011 payment will not impact the calculation of a hospital's Medicaid DSH payment amount if the hospital has not reached its DSH cap. For hospitals receiving DSH payments at or near their DSH limit, 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.

To ensure uniform and timely data transmission, we have prepared an Excel spreadsheet for States to use to transmit their DSH information to us. The information supplied on this spreadsheet would satisfy the requirements under sections 1923(a)(2)(D) and 1923(j)(1) of the Act.

B. Audit Requirements

Section 1001(d) of the MMA amended section 1923(j)(2) of the Act to require States to annually submit to CMS an independent certified audit report that verifies information about DSH payments to hospitals. The statute specifies five items that require verification by an independent audit. Collectively, these five items will 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 proposed § 455.201, we state that ''SFY'' stands for State fiscal year. In addition, we are proposing 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.

Section 1923(j) of the Act requires 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 are proposing to add a new § 455.204(a) to reflect this requirement.

As noted previously, each State must obtain an independent certified audit, beginning with an audit of its State fiscal year 2005 DSH program. We are proposing to add a new § 455.204(b) to reflect this requirement. We are proposing a submission requirement within 1 year of the independent certified audit.

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 following five items required by section 1923(j)(2) of the Act:

• Verification 1: The extent to which hospitals in the State have reduced their uncompensated care costs to reflect the

total amount of claimed expenditures made under section 1923 of the Act.

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

For purposes of Federal claiming, States report DSH expenditures to CMS. These DSH expenditures are matched at the Federal Medicaid Assistance Percentage. In some States, the non-Federal share of the DSH expenditures are funded by State and/or local government general fund appropriations. In other States, the DSH hospitals, either through intergovernmental transfers or certified public expenditures, fund the non-Federal share of the DSH expenditures. In determining compliance with the hospital-specific limit, total DSH expenditures, regardless of the source of the non-Federal share, cannot exceed the UCC.

We interpret section 1923(j)(2)(A) of the Act to require that the independent audit verify whether total claimed DSH expenditures for each hospital, including the non-Federal share, are included as revenues when determining whether DSH payments are less than or equal to each hospital's UCC. Obligations of the qualifying DSH hospital to fund the non-Federal share of a DSH payment or any other Medicaid payment cannot be included as uncompensated care for purposes of the hospital-specific DSH limit. We are proposing to add a new § 455.204(c)(1) to reflect the requirement that the audit report include a determination that qualifying hospitals in States have properly reduced their uncompensated care costs to reflect the total amount of claimed DSH expenditures.

- Verification 2: DSH payments to hospitals comply with the hospital-specific DSH limit.

We interpret section 1923(j)(2)(B) of the Act to require that the audit verify whether claimed DSH expenditures for each eligible hospital are less than or equal to the hospital's UCC. In order to evaluate compliance with this hospital-specific DSH limit, DSH payments made in the audited State fiscal year (SFY) must be measured against the actual uncompensated care costs in that same audited SFY, which for all States will begin with their respective SFY 2005. We are proposing to add a new § 455.204(c)(2) to reflect the requirement that the audit report include a determination that DSH payments to each qualifying hospital in the State comply with the hospital-specific DSH payment limit, that is, the DSH payments do not exceed the uncompensated 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 inpatient hospital and outpatient hospital services they receive.

- Verification 3: Only uncompensated care costs of providing inpatient and outpatient hospital services to Medicaid eligible individuals and uninsured individuals are included in the hospital-specific DSH payment limit.

The independent audit must verify whether the hospital-specific DSH limits calculated by the State include only costs incurred for inpatient hospital and outpatient hospital services furnished to Medicaid eligible individuals and to individuals with no source of third party coverage for the inpatient hospital and outpatient hospital services they receive.

First, the audit must verify whether the State has included only costs incurred for inpatient hospital and outpatient hospital services in the estimate of uncompensated care costs for each DSH hospital. Medicaid regulations at § 440.10 and § 440.20(a) define inpatient hospital services and outpatient hospital services, which generally include facility services furnished under the direction of a physician or dentist. The uncompensated care costs of providing physician services cannot be included in the calculation of hospital-specific DSH limit. In some circumstances, government-owned and operated hospitals fund the non-Federal share of DSH and other Medicaid payments through intergovernmental transfers to the State. These intergovernmental transfers cannot be considered an incurred cost for the purposes of calculating the hospital-specific DSH limits. The audit must verify whether the State has excluded such transfer amounts when determining hospitals' costs for the purposes of the hospital-specific DSH limits.

Second, the audit must verify that only costs incurred for Medicaid eligible individuals and uninsured individuals are included in the hospital-specific limit calculation. Medicaid eligible individuals are those individuals that a State has determined to be eligible for its Federal Medicaid program in accordance with applicable eligibility requirements. Uninsured individuals are individuals with no source of third party coverage for the inpatient hospital and outpatient hospital services they receive.

We are proposing to add a new § 455.204(c)(3) to reflect the requirement that the audit report include a determination that each qualifying hospital's DSH limit is determined by including only the uncompensated care costs for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individuals and to individuals with no source of third party coverage for the inpatient hospital and outpatient hospital services they receive.

- Verification 4: The State included all payments under this title, including supplemental payments, in the calculation of hospital-specific DSH payment limits.

This provision requires the audit to verify that all sources of Medicaid payments received by a hospital are fully counted in the State's calculation of the hospital-specific DSH limits. For example, a State might supplement the Medicaid payments that are made to hospitals under a prospective payment system with additional/enhanced non-DSH Medicaid payments. Under these circumstances, the total amount of these supplemental/enhanced Medicaid payments should be added to all other Medicaid payments received by the hospital to determine the hospital's UCC.

In addition, the audit must verify whether or not the State has properly accounted for all Medicaid payments in the calculation of uncompensated care

costs, regardless of whether Medicaid payments exceeded the incurred cost of furnishing inpatient hospital and outpatient hospital services to Medicaid patients. For purposes of this hospital-specific DSH limit, Medicaid payments made to a DSH hospital for furnishing inpatient hospital and outpatient hospital services that are in excess of the Medicaid incurred costs of such services should be applied against the uncompensated care costs of furnishing inpatient hospital and outpatient hospital services to patients with no source of third party coverage for such services. That is, Medicaid ''overpayments'' for Medicaid individuals must be used to offset any shortfalls in payment for uninsured individuals. Therefore, the audit must verify whether the State has appropriately calculated uncompensated care costs by subtracting total, combined payments for Medicaid and uninsured payments from total, combined incurred costs of 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 receive. We are proposing to add a new § 455.204(c)(4) to reflect the requirement that the audit report include a determination that States properly account for all Medicaid payments, including regular Medicaid rates and Medicaid supplemental/enhanced payments, made to hospitals for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individuals.

- Verification 5: The State has separately documented and retained a record of all its costs under this Medicaid program, claimed expenditures under this Medicaid program, uninsured costs in determining payment adjustments under this section, and any payments made on behalf of the uninsured from payment adjustments under this section.

This provision requires that the audit verify whether the State has collected and continues to maintain appropriate documentation for its calculation of hospital-specific DSH limits and for the payments made to eligible hospitals. We are proposing to add a new § 455.204(c)(5) to reflect the requirement that the audit report include a determination that the State has collected, documented, and is retaining appropriate documentation for its DSH limits calculation and payments to the qualified hospitals.

As part of the documentation verification, the audit report must describe the methodology used by the State to calculate each hospital's 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. We are proposing to add a new § 455.204(c)(6) to reflect the requirement that the audit report include a determination that each State employs an appropriate methodology for calculating the hospital-specific DSH limit.

IV. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. 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 comments on each of these issues for the information collection requirements discussed below.

The following information collection requirements and associated burdens are subject to the PRA.

We also received one public comment responding to the proposed requirements for a Medicaid Disproportionate Share Annual Report for Hospitals and Institutions in the **Federal Register** notice dated March 26, 2004, (69 FR 15853). We have determined that there was an error in the Collection of Information portion of that notice and are drafting a correction notice for publication.

Section 447.299 Reporting Requirements

In summary, paragraph (c) of this section requires the States to submit to CMS information for each DSH for the most recently-completed State 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.

Section 455.202 Audit Reporting Requirements

In summary, this section states what information must be included in the audit report.

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.

Section 455.203 Submission Date

In summary, this section requires States to submit to us an independent certified audit.

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.

We have submitted a copy of this proposed rule to OMB for its review of the information collection requirements described above. These requirements are not effective until they have been approved by OMB.

If you comment on any of these information collection and record keeping requirements, please mail copies directly to the following:

Centers for Medicare & Medicaid Services, Office of Strategic Operations and Regulatory Affairs, Regulations Development and Issuances Group, Attn: Jimmy Wickcliffe, CMS–2198–P Room C5–11–04, 7500 Security Boulevard, Baltimore, MD 21244–1850; and

Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503, Attn: Katherine Astrich, CMS Desk Officer.

Comments submitted to OMB may also be e-mailed to the following address: e-mail: *Katherine_T._Astrich*

@omb.eop.gov; or faxed to OMB at (202) 395–6974.

V. Response to Comments

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

VI. Regulatory Impact Statement

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.

Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year). This rule does not reach the economic threshold and thus is not considered a major rule.

The RFA requires agencies to analyze options for regulatory relief of small 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 $6 million to $29 million in any 1 year. Individuals and States are not included in the definition of a small entity. We are not preparing an analysis for the RFA because we have determined that this rule would not have a significant economic impact on a substantial number of small entities.

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

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in expenditure in any 1 year by State, local, or tribal governments, in the aggregate, or by the private sector, of $110 million. This rule would have no consequential effect on the governments mentioned or on the private sector.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. Since this regulation does not impose any costs on State or local governments, the requirements of 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 record keeping requirements, Rural areas.

42 CFR Part 455

Fraud, Grant programs-health, Health facilities, Health professions, Investigations, Medicaid, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services proposes to amend 42 CFR chapter IV as 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 fiscal year 2005 and each subsequent State fiscal year, States must submit to CMS the following information for each DSH hospital:

(1) *Hospital name.*

(2) *Medicare provider number.*

(3) *Medicaid provider number.*

(4) *Type of hospital.* Indicate whether the hospital is an acute, long-term care, psychiatric, teaching, children's, rehabilitation, or other facility. If other facility, specify the type.

(5) *Type of hospital ownership.* Indicate whether the hospital is owned by a private entity, State government, non-State government, the Indian Health Service, or a tribal government. Indicate whether the hospital is operated by a private entity, State government, non-State government, the Indian Health Service, or a tribal government.

(6) *Medicaid inpatient utilization rate.* Indicate the hospital's Medicaid inpatient utilization rate, as defined in section 1923(b)(2) of the Act.

(7) *Low income utilization rate.* Indicate the hospital's low income utilization rate, as defined in section 1923(b)(3) of the Act. The low income utilization rate calculation only includes individuals that have no source of third party coverage for the inpatient and/or outpatient hospital services they receive.

(8) *Disproportionate share hospital payments.* Indicate total annual payment adjustments made to the hospital under section 1923(g) of the Act.

(9) *Regular Medicaid rate payments.* Indicate the total annual amount paid to the hospital by the State, not including DSH payments or supplemental/enhanced Medicaid payments, for inpatient and outpatient services furnished to Medicaid eligible individuals.

(10) *Medicaid managed care organization payments.* Indicate 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.

(11) *Supplemental/enhanced Medicaid payments.* Indicate the total annual amount of supplemental/enhanced Medicaid payments made to the hospital by the State for inpatient hospital and outpatient hospital services furnished to Medicaid eligible individuals. These amounts do not include DSH payments, regular Medicaid rate payments, and Medicaid managed care organization payments.

(12) *Indigent care revenue.* Indicate total annual payments received by the

hospital from individuals with no source of third party coverage for inpatient and outpatient hospital services they receive.

(13) *Transfers.* Indicate the total annual amount of funds transferred by the hospital to the State or local governmental entity as a condition of the hospital receiving any Medicaid payment or DSH payment.

(14) *Total cost of care.* Indicate separately the total annual costs incurred for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individuals and 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) *Uncompensated care costs.* Indicate separately the total annual amount of uncompensated care costs 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 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 rate payments, Medicaid managed care organization payments, supplemental/enhanced Medicaid payments, and indigent care revenue. Uncompensated care costs do not include bad debt or payer discounts.

(16) *Medicaid eligible and uninsured individuals.* Indicate the total annual unduplicated number of Medicaid eligible individuals receiving inpatient hospital and outpatient hospital services and the total annual unduplicated number of individuals with no source of third party coverage for the inpatient hospital and outpatient hospital they receive.

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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 C to read as follows:

Subpart C—Independent Certified Audit of State Disproportionate Share Hospital Payment Adjustments

Sec.

Subpart C—Independent Certified Audit of State Disproportionate Share Hospital Payment Adjustments

§ 455.200 Purpose.

This subpart implements section 1923(j)(2) of the Act.

§ 455.201 Definitions.

For the purposes of this subpart—

Independent certified audit means an audit that is conducted in accordance with generally accepted government auditing standards, as defined by the Comptroller General of the United States.

SFY stands for State fiscal year.

§ 455.204 Condition for Federal financial participation (FFP).

(a) *General rule.* A State must submit an independent certified audit to CMS, according to the requirements in this subpart, to receive Federal disproportionate share hospital (DSH) payment under sections 1903(a)(1) and 1923 of the Act.

(b) *Timing.* Beginning with FY 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.

(c) *Specific requirements.* The independent certified audit report must verify the following:

(1) Each hospital that qualifies for a DSH payment in the State has reduced its uncompensated care costs for furnishing inpatient hospital and outpatient hospital services during the SFY 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) DSH payments made to each qualifying hospital comply with the hospital-specific DSH payment limit. For each audited SFY, the DSH payments made in that audited SFY must be measured against the actual uncompensated care cost in that same audited SFY.

(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 receive as described in section 1923(g)(1)(A) of the Act are included in the calculation of the hospital-specific disproportionate share limit payment limit, as described in section 1923(g)(1)(A) of the Act.

(4) For purposes of this hospital-specific limit calculation, any Medicaid payments (including regular Medicaid 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) 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) The information specified in paragraph (c)(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 receive.

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

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: January 5, 2005.

Mark B. McClellan,

Administrator, Centers for Medicare & Medicaid Services.

Approved: May 5, 2005.

Michael O. Leavitt,

Secretary.

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