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.

Subpart E—Provider Screening and Enrollment

SOURCE: 76 FR 5968, Feb. 2, 2011, unless otherwise noted.

§ 455.400 Purpose.

This subpart implements sections 1866(j), 1902(a)(39), 1902(a)(77), and 1902(a)(78) of the Act. It sets forth State plan requirements regarding the following:

(a) Provider screening and enrollment requirements.

(b) Fees associated with provider screening.

(c) Temporary moratoria on enrollment of providers.

§ 455.405 State plan requirements.

A State plan must provide that the requirements of § 455.410 through § 455.450 and § 455.470 are met.

§ 455.410 Enrollment and screening of providers.

(a) The State Medicaid agency must require all enrolled providers to be screened under to this subpart.

(b) The State Medicaid agency must require all ordering or referring physicians or other professionals providing services under the State plan or under a waiver of the plan to be enrolled as participating providers.

(c) The State Medicaid agency may rely on the results of the provider screening performed by any of the following:

(1) Medicare contractors.

(2) Medicaid agencies or Children's Health Insurance Programs of other States.

§ 455.412 Verification of provider licenses.

The State Medicaid agency must—

(a) Have a method for verifying that any provider purporting to be licensed in accordance with the laws of any State is licensed by such State.

(b) Confirm that the provider's license has not expired and that there are no current limitations on the provider's license.