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42 C.F.R. § 447.299

Reporting requirements.

(a) Beginning with the first quarter of Federal fiscal year 1993, each State must submit to CMS the quarterly aggregate amount of its disproportionate share hospital payments made to each individual public and private provider or facility. States' reports must present a complete, accurate, and full disclosure of all of their DSH programs and expenditures.

(b) Each State must report the aggregate information specified under paragraph (a) of this section on a quarterly basis in accordance with procedures established by CMS.

(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 § 455.304 of this chapter, 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 hospital services furnished to Medicaid individuals, as determined in accordance with § 447.295(d).

(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 individuals, as determined in accordance with § 447.295(d).