EXHIBIT 221

EXAMPLE OF REGULAR DISALLOWANCE LETTER

Certified Mail -- Return Receipt Requested

FILE ID: RE: File No. _____

ADDRESSEE: Dear (State Medicaid Agency Director):

INTRODUCTION: The Quarterly Statement of Expenditures, CMS-2824, submitted by your Department for the State certification program for the quarter ending _____ has been reviewed by the Regional Office. This statement contains a claim totaling $_____ in Federal financial participation (FFP) of which $_____ is being disallowed.

BACKGROUND FACTS: (Description of the issues involved and the findings of fact)

DISALLOWANCE DETERMINATION: (Citation of statute and/or regulations, an explanation of how the statute or regulation has been violated, and the decision)

CMS regulation _____ CFR _____ provides that:

(Provide explanation here.)

Therefore, in accordance with the regulation(s) cited above, this letter constitutes your notice of disallowance in the amount of $_____ FFP. Please resubmit the quarterly expenditure report for which this disallowance action was taken, making the applicable decreasing adjustments and referencing disallowance number _____.

NOTICE OF ADJUSTMENT: As this disallowance includes FFP previously paid the State for expenditures for services furnished on of after October, 1980, it is subject to the provisions of section 961(a) of the Omnibus Reconciliation Act of 1980 (Public Law 96-499) as amended by section 2163 of the Omnibus Reconciliation Act of 1982 (Public Law 97-35). If you appeal this disallowance under section 1116(d) of the Act, Public Law 96-499 provides you the option of retaining the funds disallowed by this notice pending a final administrative decision. If the final decision upholds the disallowance and you elected to retain the funds during the appeal process, the proper amount of the disallowance, plus interest computed pursuant to Public Laws 96-499 and 97-35, will be offset in a subsequent grant award. You may exercise your option to retain the

disputed funds by notifying the Regional Administrator in writing no later than 30 days after the postmarked date of this letter. In the absence of your notification that you elect to retain the funds, the Secretary will recover the disputed funds pending the final decision of the Grant Appeals Board.

APPEAL RIGHTS: Under section 1116(d) of the Social Security Act, you have the right to request reconsideration of this disallowance. If reconsideration is requested, your application must be submitted to the Executive Secretary, Departmental Grant Appeals Board, U.S. Department of Health and Human Services, Washington, D.C. 20201, no later than 30 days after your receipt of this letter. Your application must include a copy of this decision, a brief statement of the amount in dispute in your appeal, and a brief statement as to why you believe this decision in incorrect. Please send one of your application to me and one copy to the Associate Regional Administrator for Health Standards and Quality. Your application will be processed pursuant to the rules and regulations of the Departmental Grant Appeals Boards which are currently found at 45 CFR Part 16. (See "Federal Register," Vol. 46, No. 168, published August 31, 1981.)

RO PROGRAM CONTACT: Should you require further details regarding this matter, please contact the Associate Regional Administrator for Health Standards and Quality at (area code and telephone number).

Sincerely Yours,

Regional Administrator

Enclosure (if any)