STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
Lansing, Michigan

DISPROPORTIONATE SHARE PROGRAM
AGREED UPON PROCEDURES
Medicaid State Plan Rate Year September 30, 2005

TABLE OF CONTENTS

INDEPENDENT ACCOUNTANT'S REPORT
ON APPLYING AGREED-UPON PROCEDURES

Department of Community Health
Actuarial Division
Lansing, Michigan 48909

We have performed the procedures enumerated in Exhibits I, II, III, and IV of this report, which were agreed to by the State of Michigan, Department of Community Health (MDCH), solely to assist specified parties in evaluating MDCH's compliance with the Social Security Act as it related to Medicaid Disproportionate Share Hospital (DSH) payments during the period October 1, 2004 through September 30, 2005. Management is responsible for MDCH's compliance with those requirements. This agreed-upon procedures engagement was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants and the *Government Auditing Standards,* issued by the Comptroller General of the United States. The sufficiency of these procedures is solely the responsibility of those parties specified in this report. Consequently, we make no representation regarding the sufficiency of the procedures either for the purpose for which this report has been requested or for any other purpose.

Findings noted as a result of the procedures are presented in Exhibit V of this report.

We were not engaged to, and did not conduct an examination of the matters addressed herein, the objective of which would be the expression of an opinion on such information. Accordingly, we do not express such an opinion. Had we performed additional procedures, other matters might have come to our attention that would have been reported to you.

This report is intended solely for the information and use of the MDCH and the Centers for Medicare and Medicaid Services (CMS) and is not intended to be, and should not be, used by anyone other than these specified parties.

Clifton Gunderson LLP

Indianapolis, Indiana
December 13, 2010

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
OVERVIEW OF AGREED UPON PROCEDURES

The agreed upon procedures enumerated in **Exhibits II, III, and IV,** were performed to assist the Michigan Department of Community Health in evaluating its compliance with the Social Security Act (the Act) as it relates to Medicaid Disproportionate Share Hospital (DSH) payments. The objective of these procedures was 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 section 1923 of the Act.

- DSH payments to hospitals comply with the hospital-specific DSH limit as defined under Section 1923 of the Act.

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

- The State included all Medicaid payments, including supplemental payments, in the calculation of the hospital specific DSH payment limits.

- The State has separately documented and retained a record of all its costs and claimed expenditures under the Medicaid program, as well as, uninsured costs and payments used in determining the DSH payment adjustments.

- The State plan amendment includes a description of the methodology for calculating each hospital's payment limit under Section 1923(g)(1) of the Social Security Act.

The agreed upon procedures were performed in two phases. In the first phase, the DSH hospitals were subjected to desk procedures. These desk procedures were performed without an on-site review of the hospital's records; however, records were provided electronically. The specific procedures are enumerated in **Exhibit II** and **Exhibit III**. During the second phase, the procedures enumerated in **Exhibit IV** were applied at the state-wide level to the MDCH.

Our findings resulted from these procedures are described in **Exhibit V.**

SCHEDULE A
LOW PROCEDURES

Exhibit A – General Procedures

STEP NO.	PROCEDURES
1.	Perform the conversion of the finalized ECR file if received from the Medicare fiscal intermediary or the as-filed ECR if the cost report has not been finalized into the HFS software. The following steps must be completed: a. Ensure there are no variances between the cost report and the ECR file (i.e., Column 3 of the Title XIX Report 701 should be $0). b. Ensure the payment system type for Medicaid on Worksheet S-2 is ***O***. c. Ensure all Level I errors are corrected. d. Ensure that Worksheet S-2 Line 25.01 is answered Yes and Line 25.02 is answered No if provider has reported residency cost. e. Ensure that Worksheet S-2 Lines 38.01 and 38.02 are answered Yes.
2.	Determine if the provider meets **both** of the following overall DSH qualifications: a. Medicaid Day Utilization (MDU) of at least 1%. b. Obtain the names of 2 Obstetricians with staff privileges. Obtain the physician's UPIN number from the hospital and determine that the physician was licensed as an Obstetrician thru review of the Ecare website at Upin.ecare.com (Rural hospitals may use physicians with any specialty as long as they have staff privileges to perform non-emergency obstetric procedures). Determine that the physician participates in "State" Medicaid by reviewing the State's Medicaid Agency's website. This step does not apply to hospitals that did not offer non-emergency obstetric services to the general population as of December 22, 1987.
3.	Ensure the hospital has met the federal DSH criteria or the State defined DSH qualification criteria. If provider does not meet criteria, contact appropriate State personnel.

SCHEDULE A
LOW PROCEDURES

Exhibit B – Scoping and Planning Procedures

STEP NO.	PROCEDURES
1.	Maintain an adjustment summary at **W/P Ref**, on an ongoing basis, to accumulate all proposed adjustments, by period. All adjustments which will not be made must be included on the Passed Adjustment Summary located at **W/P Ref**.
2.	Maintain documentation of written communications with provider of arrangements made in Step #2.
3.	Review all pertinent provider files, including current year cost report package, most recently issued Medicare NPR, prior years' workpapers, correspondence files, permanent files, etc. Make note of any items which will require special attention and cross-reference to the appropriate workpapers.
4.	Maintain throughout the engagement procedures, a "Notes to Subsequent Reviewers" for use in following cost reporting periods. These notes should include any adjustments or items which may effect the subsequent year(s). This point sheet should be included at **W/P Ref**.
5.	Review the following from the prior year workpaper binder for possible material impact on the current year cost report: a. Notes to subsequent reviewers b. Historical clean listing from permanent file.
6.	Prepare the Engagement Planning Guide and include at **W/P Ref** ___. Conduct a planning meeting with the engagement Manager, Senior Manager, and/or Partner. Prepare budget worksheet and include at **W/P Ref** ___.

SCHEDULE A
LOW PROCEDURES

Exhibit C – WTB and Financial Statement Reconciliation

STEP NO.	PROCEDURES
1.	Determine if the State Medicaid agency has performed a review of the cost report(s) during the MSP rate year. If no review performed, proceed to step #2, otherwise procedures are complete.
2.	Determine if Medicare has issued a Notice of Provider Reimbursement (NPR) for cost report(s) during the MSP rate year. Obtain copy of the NPR. If no NPR, proceed to step #3, otherwise procedures are complete.
3.	Reconcile the expenses per the cost report (w/s A) to the WTB and the mapping schedule, in total and on a cost center basis. Address and resolve any material reconciling items. If the provider has only submitted a summary WTB showing departmental totals by cost center, obtain a detailed WTB and trace departmental totals to the detail WTB on a sample basis.
4.	Obtain the provider's revenue mapping schedule, and reconcile the gross charges per the cost report (w/s C) to the WTB in total and on a cost center basis. Address and resolve any material reconciling items, and address any material reclassifications between cost centers. If the provider has only submitted a summary WTB showing department totals by cost center, obtain a detailed WTB and trace departmental totals to the detail WTB on a sample basis.
5.	Reconcile total revenues and total expenses per the cost report to the audited financial statements. Request a clerical reconciliation from the provider, if necessary. Review material reconciling items for potential reimbursement impact and perform necessary analysis.
6.	Review the audited financial statements along with the notes for any significant items with potential uncompensated care impact. Follow-up on noted items as needed.
7.	Compare consistency of costs and charges by cost center for accurate cost to charge ratios. Obtain explanation from provider for any unusual matching of costs to charges.

SCHEDULE A
LOW PROCEDURES

Exhibit C – WTB and Financial Statement Reconciliation

STEP NO.	PROCEDURES
8.	Determine if provider is a transplant facility. If so, obtain Medicaid transplants by organ and uninsured by organ. Remove revenue from Wkst D-6, Part III. Also, determine if transplants were reimbursed through FFS, Medicaid Managed Care or Out-Of-State.
9.	Summarize all reconciling differences. Adjust cost report for allowable or non-allowable reconciling items.

SCHEDULE A
LOW PROCEDURES

Exhibit D – Medicaid Fee for Service Settlement Data

STEP NO.	PROCEDURES
1.	Obtain the Medicaid Management Information Systems (MMIS) summary report of charges, payments and days for the facility service dates during the corresponding cost reporting period from the State Medicaid Agency (or fiscal intermediary if applicable) that applies to the MSP rate year under review.
2.	Review the MMIS summary report and insure that in addition to regular Medicaid fee for service payments, the data also includes the following: a. No Pay or zero paid claims (Other third party payer pays more than the entire Medicaid payment amount) b. Medicare Crossover payments c. Third Party Payments (actual payments, not Medicaid liability) d. Coinsurance and deductible information
3.	Prepare workpaper which calculates the variances and adjustments between the amounts reported by the provider and those reflected on the MMIS summary report. Utilize the provider prepared mapping of revenue codes by cost center to the extent it is applicable, reasonable and necessary.
4.	Utilizing the MMIS summary report, propose adjustments to the following cost report worksheets as necessary: a. Medicaid Inpatient ancillary charges on worksheet D-4, and Medicaid days on worksheet S-3, Part I. b. Medicaid Outpatient ancillary charges on worksheet D Part V. c. Medicaid payments and routine charges on worksheet E-3 Part III.
5.	Summarize data for inclusion of IP/OP Medicaid fee-for-service (FFS) basic rate payments and Total cost of Care for Medicaid IP/OP Services on the PDSS.

SCHEDULE A
LOW PROCEDURES

Exhibit E – Medicaid Managed Care and Out of State Settlement Data

STEP NO.	PROCEDURES
1.	Identify Medicaid Managed Care Organizations that had members served by the provider during the portion of the cost reporting period that is within the MSP rate year. Ensure that all documentation has been obtained for these claims.
2.	Identify payments from other states for Medicaid eligible patients and for uninsured patients to whom the hospital provided services during the portion of cost reporting period that is within the MSP rate year. Ensure that documentation has been obtained for all other States.
3.	For the Medicaid out of state claims, review the MMIS summary report and insure that in addition to regular Medicaid fee for service payments, the data also includes the following: a. No Pay or zero paid claims (Other third party payer pays more than the entire Medicaid payment amount) b. Medicare Cross Over payments c. Third Party Payments (actual payments, not Medicaid liability) d. Deductibles and coinsurance amounts
4.	Prepare workpaper which calculates the variances and adjustments between the amounts reported by the provider and those reflected on the settlement data. Utilize the provider prepared mapping of revenue codes by cost center to the extent it is applicable, reasonable and necessary.
5.	Utilizing the Medicaid out of state MMIS summary report and the Medicaid MCO settlement data, propose adjustments to the following cost report worksheets as necessary: a. Medicaid Inpatient ancillary charges on worksheet D-4, and Medicaid days on worksheet S-3, Part I. b. Medicaid Outpatient ancillary charges on worksheet D Part V. c. Medicaid payments and routine charges on worksheet E-3 Part III.
6.	Summarize data for inclusion of IP/OP Medicaid managed care organization payments and Total cost of Care for Medicaid IP/OP Services on the PDSS.

SCHEDULE A
LOW PROCEDURES

Exhibit F – Review of Uninsured Charges

STEP NO.	PROCEDURES
1.	Identify and remove from the uninsured detail accounts for inpatient and/or outpatient hospital services (excl. Skilled nursing, home health, outpatient dialysis, outpatient prescription pharmacy, dental services, etc). Separate list by inpatient and outpatient hospital services.
2.	Identify and remove from the uninsured detail any duplicate entries.
3.	Identify and remove from the uninsured detail accounts that have discharge dates outside of the MSP Rate Year for inpatient services or dates of services occurred for outpatient services.
4.	Identify and remove from the uninsured detail accounts with primary payer identified.
5.	Review MMIS Report detail to remove patients included as uninsured but included on the Medicaid claims data.
6.	Identify and remove professional charges from the uninsured inpatient and outpatient hospital services.
7.	Identify any inpatient and outpatient listing for accounts that were not flagged during procedures #1-6 (Clean Listing). Place clean listings on secured website. Contact provider concerning listings placed on secured website and request summarized listing of charges and days by UB 92/04 revenue code for accounts reported on each listing. Provide deadline date for submission of charge documentation. Document conversation with provider and place in correspondence file.
8.	Identify any inpatient and outpatient listing for accounts that were flagged during procedures #1-6 (Reject Listing). Place reject listings on secured website and contact provider about the listing being placed on the website. Any documented rejected account should included listing of charges and days by UB 92/04 Revenue Code. Based on size of categories of rejected accounts, select a valid random sample of accounts for provider to submit documentation. Communicate deadline date for provider's response. Document conversation in correspondence file.

SCHEDULE A
LOW PROCEDURES

Exhibit F – Review of Uninsured Charges

STEP NO.	PROCEDURES
9.	Identify provider's classification as agreed upon with the State. a. Low DSH – Proceed to procedure #16 b. Moderate DSH – Proceed to procedure #10 c. High DSH – Proceed to procedure #11
10.	Based on Clean Listing generated, select a random sample of 81 inpatient accounts (71 for review and 10 for replacements) and 81 outpatient accounts (71 for review and 10 as replacements). The random sample is based upon attribute testing with a 90% confidence level and 10% margin of error, with four attributes. Upload sample listings to secured website. Communicate with provider concerning the upload of the samples, documentation needed for the samples and deadline date for documentation to ready for review. Document conversation with provider in correspondence file. Proceed to procedure #12.
11.	Based on Clean Listing generated, select highest dollar accounts that cover a minimum of 10% of the Clean Listing for both inpatient and outpatient accounts. In addition, select a random sample of 81 inpatient accounts (71 for review and 10 for replacements) and 81 outpatient accounts (71 for review and 10 as replacements) from the remaining population. The random sample is based upon attribute testing with a 90% confidence level and 10% margin of error, with four attributes. Upload sample listings to secured website. Communicate with provider concerning the upload of the samples, documentation needed for the samples and deadline date for documentation to ready for review. Document conversation with provider in correspondence file.

SCHEDULE A
LOW PROCEDURES

Exhibit F – Review of Uninsured Charges

STEP NO.	PROCEDURES
12.	Review each sample for the following: a. Evidence that the service was performed and is a covered service as defined by Medicaid State Plan. b. That amounts in provider uninsured charges detail are accurate. c. That the patient did not have insurance. d. That no professional fees are included in uninsured charges (including CRNA's).
13.	If professional fees are identified during the review of sample, request listing of professional fees for all accounts reported on Clean Listings.
14.	Submit through secured website sample accounts rejected during review (sample errors) to provider for provider response. Communicate deadline date for response to claims removed during review of sample. Document communication in correspondence file.
15.	Review documentation concerning sample errors and determine any modification of results as needed.
16.	Review documentation supplied by provider concerning accounts listed on sample error listing. Incorporate any accounts that are determined to be uninsured on clean listings and adjust charges by revenue code accordingly.
17.	Determine error rate of sample reviews and extrapolate error rate to Clean Listing population.
18.	Update historical listing of uninsured accounts of provider for accounts included on finalized clean listings.

SCHEDULE A
LOW PROCEDURES

Exhibit G – Review of Non-Governmental and Non-Third Payer Payments

STEP NO.	PROCEDURES
1.	Obtain Federal Section 1011 payments from provider or third party source documenting payments received during the MSP rate year under review. Documentation should be detailed by patient with account numbers or other identification indicator included.
2.	Compare detailed Federal Section 1011 payments to historical clean listings for provider to determine which payments should be included as payments on uninsured. If no detail listing was provided all Federal Section 1011 payments are considered uninsured. (As criteria for excluding Section 1011 payments, see page 77916 of the Federal Register publishing 42 CFR Parts 447 and 455 for a discussion of Section 1011 payments and why they are excluded).
3.	Review working trial balance and audited financial statements for any payments received from non-third party payers or State and Local Government indigent programs. Examples of such payments include but not limited to: a. The Ryan White HIV/AIDS Program b. Trauma Assistance Funds Not Specifically Tied To Indigent Patients c. Victim's Assistance Funds d. Provider Created Foundations e. Tobacco Settlement Fund Not Specifically Tied To Indigent Patients
4.	Request from provider a detail of payments received for funds identified in Step #3 by patient. Compare detail to historical clean listings to determine revenue that should be treated as Uninsured IP/OP Revenue. If no detail is provided, all revenue should be treated as Uninsured IP/OP Revenue.
5.	Review working trial balance and audited financial statements and provider reports of collection efforts for all uninsured patient payments and collection effort recoveries received during the Medicaid State Plan Year. (The statutory definition of uncompensated care includes the costs of furnishing hospital services to uninsured patients, minus the payments actually received from those patients. See page 77910 of the Federal Register publishing 42 CFR Parts 447 and 455 for a discussion. The statute defining this is Section 1923 (j)(2)(A) of the SSA)

SCHEDULE A
LOW PROCEDURES

Exhibit G – Review of Non-Governmental and Non-Third Payer Payments

STEP NO.	PROCEDURES
	Review detailed self pay payment listing obtained from provider with historical listing to determine the payments that should be treated as Uninsured IP/OP Revenue. If provider did not furnish self pay payment listing then treat all self pay payments provider received during the MSP rate year as Uninsured IP/OP Revenue. (Note: Auditors should be aware that they need to determine if the provider reports collection efforts back to the patient account. If so, the detail listing received for self-pay patients would include all collection efforts. If not, we need to obtain collection efforts and apply them to patient accounts).
6.	Summarize Federal Applicable Section 1011 Payments and Uninsured IP/OP Revenue and adjust the Provider Data Summary Schedule (PDSS).

SCHEDULE A
LOW PROCEDURES

Exhibit H – Miscellaneous Hospital Reporting Provisions

STEP NO.	PROCEDURES
1.	If hospital qualified under State Defined DSH Qualification Criteria then proceed to Step #4 otherwise complete Step #2 or Step #3 based on PDSS.
2.	Determine Medicaid Inpatient Utilization Rate based on updated Medicaid eligible days determined under review of FFS Medicaid and Non-FFS Medicaid. Divide Medicaid eligible days by total days to determine utilization rate. Total days should include both acute and sub-provider days but exclude observation days. Adjust PDSS for updated Medicaid Inpatient Utilization Rate.
3.	If Low Income Utilization Rate is reported by provider, obtain provider's documentation for charity care patients. Determine if information is reasonable and re-calculate as necessary. Adjust PDSS for updated Low Income Utilization Rate.
4.	Obtain documentation from Provider and State regarding Supplemental/Enhanced payments made to hospital for MSP rate year. Supplemental/Enhanced payments include the following: a. Upper Payment Limit Payments for inpatient and outpatient services b. Cost report settlements (tentative and/or final) c. Additional payments for graduate medical education d. Any additional payments made for inpatient and outpatient services not covered under 42 CFR §447.299(c)(6) For any payments made based on provider fiscal year as opposed to MSP rate year, allocate payment based on percentage of months of the fiscal year within the MSP rate year. Adjust Supplemental/Enhanced Medicaid IP/OP Payments on the Provider Data Summary Schedule.

SCHEDULE A
LOW PROCEDURES

Exhibit H – Miscellaneous Hospital Reporting Provisions

STEP NO.	PROCEDURES
5.	Obtain documentation from Provider and Medicaid Managed Care Organizations regarding Supplemental/Enhanced payments made to hospital for MSP rate year. Supplemental/Enhanced payments include the following: a. Upper Payment Limit Payments for inpatient and outpatient services b. Additional payments for graduate medical education c. Any additional payments made for inpatient and outpatient services not covered under 42 CFR §447.299(c)(7) For any payments made based on provider fiscal year as opposed to MSP rate year, allocate payment based on percentage of months of the fiscal year within the MSP rate year. Adjust IP/OP Medicaid Managed Care Organization Payments on the Provider Data Summary Schedule.
6.	Obtain documentation from Provider and Out Of State Medicaid Agencies regarding Supplemental/Enhanced payments made to hospital for MSP rate year. Supplemental/Enhanced payments include the following: a. Upper Payment Limit Payments for inpatient and outpatient services b. Cost report settlements (tentative and/or final) c. Additional payments for graduate medical education d. Any additional payments made for inpatient and outpatient services not covered under 42 CFR §447.299(c)(7) For any payments made based on provider fiscal year as opposed to MSP rate year, allocate payment based on percentage of months of the fiscal year within the MSP rate year. Adjust IP/OP Medicaid Managed Care Organization Payments on the Provider Data Summary Schedule.

SCHEDULE A
LOW PROCEDURES

Exhibit H – Miscellaneous Hospital Reporting Provisions

STEP NO.	PROCEDURES
7.	Summarize Disproportionate Share Hospital Payments and supplemental/enhanced Medicaid payments the provider has received from Supplemental/Enhanced payments, Medicaid Managed Care Organizations and Out of State Medicaid Agencies
8.	Verify that DSH funds received by the providers reconcile with the amount reported as paid by the state.
9.	Verify that the state has not required providers to IGT DSH funds back to the state after disbursement.
10.	Verify with provider if any redistribution or recovery has been made based on identification of DSH payments made in excess of hospital specific limits. If so, obtain documentation from the provider that the redistribution or recovery was made based on the results of the hospital verification procedures.

SCHEDULE A
LOW PROCEDURES

Exhibit I – Final Report on Hospital/Completion of Procedures

STEP NO.	PROCEDURES
1.	Send the provider a copy of the adjustments. Obtain and document the provider's responses to the adjustments. **Important-** File a copy of the adjustments given to the provider at workpaper W/P Ref.
2.	Incorporate adjustments into the CMS Form 2552 software utilizing the Medicare Auditor function and produce a Level I error free cost report. Maintain a CMS 2552 for out of State Medicaid and Medicaid MCO as one report, Medicaid FFS as a second report, and Medicaid Uninsured as a third report.
3.	Conduct detailed level review of adjustments
4.	Complete Provider Data Summary Schedule (PDSS) for incorporation into review of the State Medicaid Disproportionate Share Program.

SCHEDULE A
MINIMAL PROCEDURES

Exhibit A – General Procedures

STEP NO.	PROCEDURES
1.	Perform the conversion of the finalized ECR file if received from the Medicare fiscal intermediary or the as-filed ECR if the cost report has not been finalized into the HFS software. The following steps must be completed: a. Ensure there are no variances between the cost report and the ECR file (i.e., Column 3 of the Title XIX Report 701 should be $0) b. Ensure the payment system type for Medicaid on Worksheet S-2 is ***O***. c. Ensure all Level I errors are corrected. d. Ensure that Worksheet S-2 Line 25.01 is answered Yes and Line 25.02 is answered No if provider has reported residency cost. e. Ensure that Worksheet S-2 Lines 38.01 and 38.02 are answered Yes.
2.	Determine if the provider meets **both** of the following overall DSH qualifications: a. Medicaid Day Utilization (MDU) of at least 1%. b. Obtain the names of 2 Obstetricians with staff privileges. Obtain the physician's UPIN number from the hospital and determine that the physician was licensed as an Obstetrician thru review of the Ecare website at Upin.ecare.com (Rural hospitals may use physicians with any specialty as long as they have staff privileges to perform non-emergency obstetric procedures). Determine that the physician participates in "State" Medicaid by reviewing the State's Medicaid Agency's website. This step does not apply to hospitals that did not offer non-emergency obstetric services to the general population as of December 22, 1987.
3.	Ensure the hospital has met the federal DSH criteria or the State defined DSH qualification criteria. If provider does not meet criteria, contact appropriate State personnel.

SCHEDULE A
MINIMAL PROCEDURES

Exhibit B – Scoping and Planning Procedures

STEP NO.	PROCEDURES
1.	Maintain documentation of written communications with provider,
2.	Review all pertinent provider files, including current year cost report package, most recently issued Medicare NPR, prior years' workpapers, correspondence files, permanent files, etc. Make note of any items which will require special attention and cross-reference to the appropriate workpapers.
3.	Maintain throughout the engagement procedures, a "Notes to Subsequent Reviewers" for use in following cost reporting periods. These notes should include any adjustments or items which may effect the subsequent year(s). This point sheet should be included at **W/P Ref.**
4.	Review the following from the prior year workpaper binder for possible material impact on the current year cost report: a. Notes to subsequent reviewers b. Historical clean listing from permanent file.
5.	Prepare the Engagement Planning Guide and include at **W/P Ref.** Conduct a planning meeting with the engagement Manager, senior Manager, and/or Partner. Prepare budget worksheet and include at **W/P Ref.**

SCHEDULE A
MINIMAL PROCEDURES

Exhibit C – WTB and Financial Statement Reconciliation

STEP NO.	PROCEDURES
1.	Determine if the State Medicaid agency has performed a review of the cost report(s) during the MSP rate year. If no review performed, proceed to step #2, otherwise procedures are complete.
2.	Determine if Medicare has issued a Notice of Provider Reimbursement (NPR) for cost report(s) during the MSP rate year. Obtain copy of the NPR. If no NPR, proceed to step #3, otherwise procedures are complete.
3.	Obtain the provider's working trial balance (WTB). Perform a cursory review of the trial balance for any material issues.
4.	Obtain the provider's revenue mapping schedule.
5.	Review the audited financial statements along with the notes for any significant items with potential uncompensated care impact. Follow-up on noted items as needed.
6.	Adjust cost report for allowable or non-allowable reconciling items.

SCHEDULE A
MINIMAL PROCEDURES

Exhibit D – Medicaid Fee for Service Settlement Data

STEP NO.	PROCEDURES
1.	Obtain the Medicaid Management Information Systems (MMIS) summary report of charges, payments and days for the facility service dates during the corresponding cost reporting period from the State Medicaid Agency (or fiscal intermediary if applicable) that applies to the MSP rate year under review.
2.	Review the MMIS summary report and insure that in addition to regular Medicaid fee for service payments, the data also includes the following: a. No Pay or zero paid claims (Other third party payer pays more than the entire Medicaid payment amount) b. Medicare Crossover payments c. Third Party Payments (actual payments, not Medicaid liability) d. Coinsurance and deductible information
3.	Summarize data for inclusion of IP/OP Medicaid fee-for-service (FFS) basic rate payments and Total cost of Care for Medicaid IP/OP Services on the PDSS.

SCHEDULE A
MINIMAL PROCEDURES

Exhibit E – Medicaid Managed Care and Out of State Settlement Data

STEP NO.	PROCEDURES
1.	Identify Medicaid Managed Care Organizations that had members served by the provider during the portion of the cost reporting period that is within the MSP rate year. Ensure that all documentation has been obtained for these claims.
2.	Identify payments from other states for Medicaid eligible patients and for uninsured patients to whom the hospital provided services during the portion of cost reporting period that is within the MSP rate year. Ensure that documentation has been obtained for all other States.
3.	For the Medicaid out of state claims, review the MMIS summary report and insure that in addition to regular Medicaid fee for service payments, the data also includes the following: a. No Pay or zero paid claims (Other third party payer pays more than the entire Medicaid payment amount) b. Medicare Cross Over payments c. Third Party Payments (actual payments, not Medicaid liability) d. Deductibles and coinsurance amounts
4.	Summarize data for inclusion of IP/OP Medicaid managed care organization payments and Total cost of Care for Medicaid IP/OP Services on the PDSS.

SCHEDULE A
MINIMAL PROCEDURES

Exhibit F – Review of Uninsured Charges

STEP NO.	PROCEDURES
1.	Use total uninsured charges (making sure that professional charges have been excluded) and calculated facility overall cost-to-charge ration (using total charges and total costs from Worksheet B and Worksheet C of the cost report) to calculate uninsured costs.
2.	Compare uninsured costs to uninsured payments, note any uninsured profit/loss. (This will be carried forward to the PDSS).

SCHEDULE A
MINIMAL PROCEDURES

Exhibit G – Review of Non-Governmental and Non-Third Payer Payments

STEP NO.	PROCEDURES
1.	Obtain Federal Section 1011 payments from provider or third party source documenting payments received during the MSP rate year under review. Documentation should be detailed by patient with account numbers or other identification indicator included.
2.	Summarize Federal Applicable Section 1011 Payments and Uninsured IP/OP Revenue and adjust the Provider Data Summary Schedule (PDSS).

SCHEDULE A
MINIMAL PROCEDURES

Exhibit H – Miscellaneous Hospital Reporting Provisions

STEP NO.	PROCEDURES
1.	If hospital qualified under State Defined DSH Qualification Criteria then proceed to Step #4 otherwise complete Step #2 or Step #3 based on PDSS.
2.	Determine Medicaid Inpatient Utilization Rate based on updated Medicaid eligible days determined under review of FFS Medicaid and Non-FFS Medicaid. Divide Medicaid eligible days by total days to determine utilization rate. Total days should include both acute and sub-provider days but exclude observation days. Adjust PDSS for updated Medicaid Inpatient Utilization Rate.
3.	If Low Income Utilization Rate is reported by provider, obtain provider's documentation for charity care patients. Determine if information is reasonable and re-calculate as necessary. Adjust PDSS for updated Low Income Utilization Rate.
4.	Obtain documentation from Provider and State regarding Supplemental/Enhanced payments made to hospital for MSP rate year. Supplemental/Enhanced payments include the following: a. Upper Payment Limit Payments for inpatient and outpatient services b. Cost report settlements (tentative and/or final) c. Additional payments for graduate medical education d. Any additional payments made for inpatient and outpatient services not covered under 42 CFR §447.299(c)(6) For any payments made based on provider fiscal year as opposed to MSP rate year, allocate payment based on percentage of months of the fiscal year within the MSP rate year. Adjust Supplemental/Enhanced Medicaid IP/OP Payments on the Provider Data Summary Schedule.

SCHEDULE A
MINIMAL PROCEDURES

Exhibit H – Miscellaneous Hospital Reporting Provisions

STEP NO.	PROCEDURES
5.	Obtain documentation from Provider and Medicaid Managed Care Organizations regarding Supplemental/Enhanced payments made to hospital for MSP rate year. Supplemental/Enhanced payments include the following: a. Upper Payment Limit Payments for inpatient and outpatient services b. Additional payments for graduate medical education c. Any additional payments made for inpatient and outpatient services not covered under 42 CFR §447.299(c)(7) For any payments made based on provider fiscal year as opposed to MSP rate year, allocate payment based on percentage of months of the fiscal year within the MSP rate year. Adjust IP/OP Medicaid Managed Care Organization Payments on the Provider Data Summary Schedule.
6.	Obtain documentation from Provider and Out Of State Medicaid Agencies regarding Supplemental/Enhanced payments made to hospital for MSP rate year. Supplemental/Enhanced payments include the following: a. Upper Payment Limit Payments for inpatient and outpatient services b. Cost report settlements (tentative and/or final) c. Additional payments for graduate medical education d. Any additional payments made for inpatient and outpatient services not covered under 42 CFR §447.299(c)(7) For any payments made based on provider fiscal year as opposed to MSP rate year, allocate payment based on percentage of months of the fiscal year within the MSP rate year. Adjust IP/OP Medicaid Managed Care Organization Payments on the Provider Data Summary Schedule.
7.	Summarize Disproportionate Share Hospital Payments and supplemental/enhanced Medicaid payments the provider has received from Supplemental/Enhanced payments, Medicaid Managed Care Organizations and Out of State Medicaid Agencies

SCHEDULE A
MINIMAL PROCEDURES

Exhibit I – Final Report on Hospital/Completion of Procedures

STEP NO.	PROCEDURES
1.	Send the provider a copy of the adjustments. Obtain and document the provider's responses to the adjustments. **Important-** File a copy of the adjustments given to the provider at workpaper W/P Ref.
2.	Incorporate adjustments into the CMS Form 2552 software utilizing the Medicare Auditor function and produce a Level I error free cost report. Maintain a CMS 2552 for out of State Medicaid and Medicaid MCO and Medicaid FFS as a report and Medicaid Uninsured as a third report.
3.	Conduct detailed level review of adjustments
4.	Complete Provider Data Summary Schedule (PDSS) for incorporation into review of the State Medicaid Disproportionate Share Program.

SCHEDULE A
PROCEDURES

Exhibit A – General Planning Procedures

STEP NO.	PROCEDURES
1.	Obtain State agreement for the agreed upon procedures that will be conducted.
2.	Maintain throughout the engagement a "Notes to Subsequent Auditors" for use in following cost reporting periods. A copy of this point sheet should be included at **W/P Ref**.
3.	Obtain State's estimate of hospital specific DSH limit that was determined when the DSH payments for the Medicaid State Plan (MSP) rate year were calculated.
4.	Accumulate Provider Data Summary Schedule (PDSS) and note any differences from State's DSH Reporting Schedule (DRS).

SCHEDULE A
PROCEDURES

Exhibit B – Verification One

STEP NO.	PROCEDURES
1.	Verify from state documentation that each hospital has met the federal DSH criteria or the State defined DSH qualification criteria for the MSP rate year under review.
2.	Verify that the state has not required providers to IGT DSH funds back to the state after disbursement. Identify the different funding mechanisms used and follow the procedures identified below to verify that the state is not reducing providers' DSH payments by the amount of any IGT, provider tax, or other funding mechanism, and that the DSH payment equals the CPE.
3.	If the State uses Certified Public Expenditures (CPE), verify that the DSH payment agrees to CPE filed by the State for claiming of Federal funds.
4.	If the State uses Intergovernmental Transfers (IGT), verify that the State receives an IGT from the providers. Verify that the provider received the full DSH payment in a separate transaction.
5.	If state funds (or other tax receipts) finance the DSH program, verify that the entire state and federal components are retained by the provider.
6.	Verify with State if any redistribution or recovery has been made based on identification of DSH payments made in excess of hospital specific limits. If so, obtain documentation from the State that the redistribution or recovery was made based on the results of the hospital verification procedures.
7.	Verify that state has updated DRS to include DSH Payments made by Out of State Medicaid State Agencies.
8.	Generate verification assessment language for Verification One based on results of procedures.

SCHEDULE A
PROCEDURES

Exhibit C – Verification Two

STEP NO.	PROCEDURES
1.	Prepare summary schedule detailing the State's procedures performed to determine whether or not the State made DSH payments that exceeded any provider's specific DSH limit during the Medicaid State plan rate year.
2.	Utilizing the individual Provider Data Summary Schedules, summarize the hospital-specific uncompensated care costs incurred during the Medicaid State plan year under examination. Compare hospital-specific DSH payments to the uncompensated care costs and note any providers where the DSH payments exceeded the hospital-specific uncompensated care costs.
3.	Prepare verification assessment language for Verification #2 to note whether the State's procedures satisfy the Federal regulation at Section 1923(g)(1)(A) of the Act and that identify any providers that exceeded their hospital-specific DSH payment limit.

SCHEDULE A
PROCEDURES

Exhibit D – Verification Three

STEP NO.	PROCEDURES
1.	Prepare summary schedule detailing the State's procedures performed to determine that only the uncompensated care costs of providing inpatient and outpatient hospital services to Medicaid eligible individuals and uninsured individuals are included in the calculation of the hospital-specific limits.
2.	Assess whether the state's procedures only use uncompensated care costs of i/p and o/p hospital services in calculation of hospital specific limits.
3.	Prepare verification assessment language for Verification #3 to note whether the State's procedures satisfy the Federal regulation at Section 1923(g)(1)(A) of the Act.

SCHEDULE A
PROCEDURES

Exhibit E – Verification Four

STEP NO.	PROCEDURES
1.	Prepare summary schedule detailing the State's procedures performed to determine that all payments (Medicaid FFS, Medicaid managed care, and supplemental/enhanced Medicaid payments) have been included in the calculation of the hospital-specific DHS limits.
2.	Assess whether the state's procedures take into account all payments (Medicaid FFS, Medicaid managed care, and supplemental/enhanced Medicaid payments) in the calculation of hospital specific limits.
3.	Prepare verification assessment language for Verification #4 to note whether the State's procedures satisfy the Federal regulation at Section 1923 of the Act.

SCHEDULE A
PROCEDURES

Exhibit F – Verification Five

STEP NO.	PROCEDURES
1.	Obtain copies of the State's policies and procedures regarding documentation retention related to information and records of all 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; and, any payments made on behalf of the uninsured from payment adjustments under Section 1923 of the Act.
2.	Prepare summary schedule detailing the State's documentation procedures including the specific data elements retained by the State.
3.	Assess whether the state has documented and retained 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.
4.	Prepare verification assessment language for Verification #5 to note whether the State's procedures satisfy the Federal regulation at Section 1923 of the Act.

SCHEDULE A
PROCEDURES

Exhibit G – Verification Six

STEP NO.	PROCEDURES
1.	Obtain documentation from the State outlining the methodology used to calculate the hospital-specific DSH limit and methodology used to calculate the various DSH payments. Review for compliance with applicable regulations.
2.	Review state's DSH procedures to ensure consistency with IP/OP Medicaid reimbursable services in the approved Medicaid State Plan.
3.	Review DSH procedures to ensure that only costs eligible for DSH payments are included in the development of the hospital specific DSH limit.
4.	Review State Plan section covering DSH payments to ensure it complies with applicable Federal regulations.
5.	Assess and document 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.
6.	Prepare verification assessment language for Verification Six to note whether the State's procedures satisfy the Federal regulation at Section 1923 of the Act.

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
OVERVIEW OF MICHIGAN DISPROPORTIONATE SHARE PROGRAM

The disproportionate share hospital (DSH) program originated with the Omnibus Budget Reconciliation Act (OBRA) of 1981, which required state Medicaid agencies to make additional payments to hospitals serving disproportionate numbers of low-income patients with special needs. States had considerable flexibility to define DSH under sections 1923(a) and (b) of the Social Security Act (the Act).

Section 13261 of OBRA 1993 amended section 1923 of the Act to limit DSH payments to the amount of a hospital's incurred uncompensated care costs (UCC). The UCC was limited to the costs of medical services provided to Medicaid and uninsured patients less payments received for those patients, excluding Medicaid DSH payments.

According to Michigan's State Medicaid Plan, hospitals must satisfy the following criteria to qualify for the Michigan DSH program:

a. Hospitals must have a Medicaid Inpatient Utilization Rate (MIUR) of at least 1%.

b. Hospitals must supply indigent volume data to MDCH.

In addition to meeting the MIUR identified above, hospitals must also satisfy one of the following four criteria in order to qualify for the Michigan DSH program:

a. Hospitals must have at least two (2) obstetricians with staff privileges who have agreed to provide obstetrical services to individuals who are eligible for Medicaid services.

b. Hospitals must be located in a rural area (as defined for purposes of section 1886 of the Social Security Act) and have at least two (2) physicians with staff privileges at the hospital who have agreed to provide obstetric services to individuals who are eligible for Medicaid services.

c. Hospitals must serve as inpatients a population predominantly comprised of individuals under 18 years of age.

d. As of December 22, 1987, not have offered non-emergency obstetric services to the general population.

According to Michigan's State Plan, DSH payments to qualifying hospitals are calculated as follows:

Hospitals are grouped into six different distribution pools based on indigent volume, public vs. private hospitals, Indigent Care Agreements, Managed Care agreements, the amount of DSH funding received in 2004, and state owned psychiatric hospitals. Hospitals may qualify for multiple pools.

The six different distribution pools are allocated further once the total pool amount has been established. The pool allocations for the Regular DSH pool is determined by the percentage of DSH shares for the pool to total DSH shares. The Regular DSH pool is further broken down into pools based on reimbursement methodology (DRG vs. per diem) and the amount of indigent volume. Additionally, distinct part rehabilitation units have a separate pool within the Regular DSH pool.

The Indigent Care Agreements (ICA) pool requires hospitals to maintain an ICA with a partner health care related entity in the area.

The Managed Care Pool makes payments to only one hospital. To qualify for this special pool, the hospital must have an agreement with a university with a college of allopathic medicine and a college of osteopathic medicine.

The small hospital pool is a single pool. To qualify for this pool, a hospital and hospital system must have received less than $900,000 in regular DSH funding during Medicaid State Plan year 2004.

The state owned psychiatric hospitals are included in a separate pool established only for those hospitals. The payments for this pool are limited to uncompensated care costs per the State Plan.

The State Plan indicates that the public hospitals will receive DSH payments up to the hospital specific limit amount.

The State Plan does not have any provisions to compare the hospitals' individual DSH payments to the hospitals' uncompensated care costs as described in Section 1923 of the Act. In 2005, the State did compare the DSH payments of each individual hospital to uncompensated care costs (from 2003, as reported by the hospitals), and limited payments to the uncompensated care costs. However, this is not prescribed in the State Plan except for the state owned psychiatric hospitals.

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
DISPROPORTIONATE SHARE HOSPITAL DATA REPORTING FORM
MEDICAID STATE PLAN RATE YEAR 2005

	2	3	4	5	6	7	8	9	10	11
Hospital Name	Medicaid IP Utilization Rate	Low-Income Utilization Rate	State-Defined DSH Qualification Criteria	Regular IP/OP Medicaid FFS Basic Rate Payments	IP/OP Medicaid MCO Payments	Supplemental/ Enhanced IP/OP Medicaid Payments	Total Medicaid IP/OP Payments	Total Cost of Care - Medicaid IP/OP Services	Total Medicaid Uncompensated Care	Uninsured IP/OP Revenue
Allegan General Hospital	35.84%	Note 2	Note 1	$ 581,696	$ -	$ 502,335	$ 1,084,031	$ 1,387,327	$ 303,296	$ -
Alpena General Hospital	11.81%	Note 2	Note 1	$ 7,698,405	$ 1,034,078	$ 1,133,068	$ 9,865,551	$ 9,225,939	$ (639,612)	$ 33,141
Baraga County Memorial Hospital	5.82%	Note 2	Note 1	$ 150,401	$ -	$ 195,960	$ 346,361	$ 348,730	$ 2,369	$ -
Battle Creek Health System	17.32%	Note 2	Note 1	$ 11,038,576	$ 4,985,489	$ 3,588,714	$ 19,612,779	$ 21,565,259	$ 1,952,480	$ 185,604
Bay Medical Center	12.26%	Note 2	Note 1	$ 15,004,879	$ 11,574,906	$ 2,991,369	$ 29,571,154	$ 126,576,129	$ 97,004,975	$ -
Bell Memorial Hospital	33.09%	Note 2	Note 4	$ 451,786	$ -	$ 611,966	$ 1,063,752	$ 1,042,754	$ (20,998)	$ -
Bi-County Community Hospital	7.57%	Note 2	Note 1	$ 2,304,320	$ -	$ 1,838,836	$ 4,143,156	$ 6,914,240	$ 2,771,084	$ 419,650
Borgess Hospital	14.35%	Note 2	Note 1	$ 31,404,614	$ 10,265,683	$ 6,339,193	$ 48,009,490	$ 499,699,620	$ 451,690,130	$ 965,640
Botsford General Hospital	10.78%	Note 2	Note 1	$ 21,107,841	$ 7,638,901	$ 4,542,593	$ 33,289,335	$ 34,740,665	$ 1,451,330	$ 1,083,912
Bronson Methodist Hospital	24.65%	Note 2	Note 1	$ 19,411,455	$ 17,078,840	$ 12,101,784	$ 48,592,079	$ 48,962,070	$ 369,991	$ 875,674
Bronson Vicksburg Hospital	7.36%	Note 2	Note 1	$ 286,379	$ -	$ 145,312	$ 431,691	$ 543,352	$ 111,661	$ -
Caro Community Hospital	4.49%	Note 2	Note 1	$ 123,568	$ 1,234,504	$ 99,099	$ 1,457,171	$ 1,550,053	$ 92,882	$ -
Carson City Osteopathic Hospital	20.17%	Note 2	Note 1	$ 602,723	$ -	$ 566,396	$ 1,169,119	$ 988,307	$ (180,812)	$ 149,108
Central Michigan Community Hospital	14.17%	Note 2	Note 1	$ 5,592,179	$ 556,801	$ 1,592,649	$ 7,741,629	$ 7,886,626	$ 144,997	$ 327,785
Charlevoix Area Hospital	20.30%	Note 2	Note 1	$ 2,018,532	$ 62,071	$ 566,415	$ 2,647,018	$ 2,665,622	$ 18,604	$ 115,365
Cheboygan Memorial Hospital	13.32%	Note 2	Note 1	$ 1,874,794		$ 1,015,057	$ 2,889,851	$ 2,833,888	$ (55,963)	$ -
Chelsea Community Hospital	7.33%	Note 2	Note 1	$ 859,448	$ 1,176,936	$ 154,319	$ 2,190,703	$ 3,084,102	$ 893,399	$ -
Children's Hospital of Michigan **Note 6**	63.33%	Note 2	Note 1	$ 37,518,921	$ 26,838,662	$ 47,044,674	$ 111,402,257	$ 125,524,415	$ 14,122,158	$ -
Chippewa War Memorial Hospital	8.77%	Note 2	Note 1	$ 5,808,247	$ -	$ 887,042	$ 6,695,289	$ 8,630,167	$ 1,934,878	$ 98,354
Clinton Memorial Hospital	5.16%	Note 2	Note 1	$ 120,278	$ 17	$ 105,528	$ 225,823	$ 350,363	$ 124,540	$ 97,350
Community Health Center of Branch County	12.42%	Note 2	Note 1	$ 1,230,544		$ 758,601	$ 1,989,145	$ 1,955,529	$ (33,616)	$ -
Community Hospital - Watervliet	13.34%	Note 2	Note 1	$ 2,770,533	$ 1,698,112	$ 663,657	$ 5,132,302	$ 4,370,890	$ (761,412)	$ 275,197
Cottage Hospital of Grosse Pointe	0.83%	Note 2	Note 3	$ 120,366	$ -	$ 163,679	$ 284,045	$ 262,438	$ (21,607)	$ 199,275
Covenant Medical Center, Inc.	15.42%	Note 2	Note 1	$ 13,669,592	$ 18,682,436	$ 9,273,380	$ 41,625,408	$ 35,510,794	$ (6,114,614)	$ -
Crittenton Hospital	7.64%	Note 2	Note 1	$ 1,589,272	$ 425,327	$ 690,253	$ 2,704,852	$ 3,958,032	$ 1,253,180	$ -
Detroit Receiving Hospital **Note 6**	36.70%	Note 2	Note 1	$ 14,091,580	$ 29,538,212	$ 21,716,711	$ 65,346,503	$ 61,866,332	$ (3,480,171)	$ -
Dickinson County Memorial Hospital	6.86%	Note 2	Note 1	$ 3,053,788	$ 1,123,670	$ 534,878	$ 4,712,336	$ 8,150,038	$ 3,437,702	$ 148,330
Edward W. Sparrow Hospital	17.78%	Note 2	Note 1	$ 16,046,989	$ 15,861,898	$ 15,068,534	$ 46,977,421	$ 53,994,637	$ 7,017,216	$ 530,145
Emma L. Bixby Medical Center	14.59%	Note 2	Note 1	$ 7,148,402	$ -	$ 1,183,507	$ 8,331,909	$ 9,249,618	$ 917,709	$ -
Garden City Osteopathic Hospital	12.91%	Note 2	Note 1	$ 10,558,465	$ 3,523,411	$ 2,738,520	$ 16,820,396	$ 16,503,355	$ (317,041)	$ 25,843
Genesys Regional Medical Center	11.25%	Note 2	Note 1	$ 26,306,623	$ 16,469,640	$ 16,162,969	$ 58,939,232	$ 61,896,952	$ 2,957,720	$ 341,022
Gerber Memorial Hospital **Note 6**	28.89%	Note 2	Note 1	$ 1,050,247		$ 670,119	$ 1,720,366	$ 2,211,491	$ 491,125	$ -
Grand View Hospital	14.92%	Note 2	Note 1	$ 377,340	$ -	$ 225,185	$ 602,525	$ 572,886	$ (29,639)	$ -
Gratiot Community Hospital	9.94%	Note 2	Note 1	$ 2,037,250		$ 1,299,605	$ 3,336,855	$ 3,307,718	$ (29,137)	$ -
Hackley Hospital	17.22%	Note 2	Note 1	$ 3,569,033	$ -	$ 2,363,900	$ 5,932,933	$ 5,726,059	$ (206,874)	$ -
Harper University Hospital **Note 6**	38.96%	Note 2	Note 1	$ 6,125,736	$ 59,515,991	$ 33,883,168	$ 99,524,895	$ 164,794,660	$ 65,269,765	$ -
Hayes Green Beach Memorial Hospital	19.69%	Note 2	Note 1	$ 578,948	$ -	$ 348,626	$ 927,574	$ 990,062	$ 62,488	$ 310,286
Healthsource Saginaw	25.40%	Note 2	Note 1	$ 157,805	$ -	$ 87,339	$ 245,144	$ 204,705	$ (40,439)	$ 91,796
Helen Newberry Joy Hospital	4.75%	Note 2	Note 1	$ 163,188	$ 577,611	$ 119,906	$ 860,705	$ 2,301,038	$ 1,440,333	$ 187,919
Henry Ford Hospital	16.52%	Note 2	Note 1	$ 28,600,450	$ 29,836,375	$ 27,024,081	$ 85,460,906	$ 82,825,095	$ (2,635,811)	$ 10,243,827
Henry Ford Wyandotte Hospital	11.22%	Note 2	Note 1	$ 1,849,780	$ 8,378,994	$ 2,726,243	$ 12,955,017	$ 14,630,018	$ 1,675,001	$ 2,478,833
Herrick Memorial Hospital, Inc.	14.77%	Note 2	Note 1	$ 1,740,230	$ 839,966	$ 306,257	$ 2,886,453	$ 4,020,408	$ 1,133,955	$ -
Hills & Dales General Hospital	8.41%	Note 2	Note 1	$ 106,886	$ -	$ 113,912	$ 220,798	$ 258,166	$ 37,368	$ 17,143
Hillsdale Community Health Center	14.75%	Note 2	Note 1	$ 1,716,867		$ 624,598	$ 2,341,465	$ 2,983,816	$ 642,351	$ 372,534
Holland Community Hospital	15.12%	Note 2	Note 1	$ 2,506,595	$ 3,881,513	$ 1,714,577	$ 8,102,685	$ 11,461,386	$ 3,358,701	$ 575,963
Hurley Medical Center	39.55%	Note 2	Note 1	$ 42,347,218	$ 35,937,686	$ 18,294,794	$ 96,579,698	$ 94,577,573	$ (2,002,125)	$ 161,607
Huron Memorial Hospital	18.67%	Note 2	Note 1	$ 509,112	$ -	$ 421,128	$ 930,240	$ 1,057,522	$ 127,282	$ -
Ingham Regional Medical Center	10.49%	Note 2	Note 1	$ 20,016,412	$ 9,033,932	$ 4,348,898	$ 33,399,242	$ 42,536,142	$ 9,136,900	$ 181,647
Ionia County Memorial Hospital	20.17%	Note 2	Note 1	$ 601,817	$ -	$ 345,716	$ 947,533	$ 1,387,258	$ 439,725	$ 186,997
Kalkaska Memorial Health Center	6.87%	Note 2	Note 1	$ 337,446	$ -	$ 211,297	$ 548,743	$ 1,159,522	$ 610,779	$ 3,923
Keweenaw Memorial Medical Center	14.36%	Note 2	Note 1	$ 304,997	$ 452,809	$ 222,144	$ 979,950	$ 1,983,877	$ 1,003,927	$ 84,664
Lake View Community Hospital	3.94%	Note 2	Note 1	$ 324,757	$ 916,787	$ 302,735	$ 1,544,279	$ 2,558,772	$ 1,014,493	$ 343,904
Lakeland Hospital - St. Joseph	17.76%	Note 2	Note 1	$ 6,202,880	$ 14,748,929	$ 3,894,328	$ 24,846,137	$ 68,630,392	$ 43,784,255	$ -
Lakeshore Community Hospital	29.50%	Note 2	Note 1	$ 476,062	$ -	$ 378,431	$ 854,493	$ 816,653	$ (37,840)	$ -
Lapeer Regional Hospital	14.73%	Note 2	Note 1	$ 4,163,749	$ 557,632	$ 1,085,497	$ 5,806,878	$ 5,535,079	$ (271,799)	$ 264,900

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
DISPROPORTIONATE SHARE HOSPITAL DATA REPORTING FORM
MEDICAID STATE PLAN RATE YEAR 2005

	2	3	4	5	6	7	8	9	10	11
Hospital Name	Medicaid IP Utilization Rate	Low-Income Utilization Rate	State-Defined DSH Qualification Criteria	Regular IP/OP Medicaid FFS Basic Rate Payments	IP/OP Medicaid MCO Payments	Supplemental/ Enhanced IP/OP Medicaid Payments	Total Medicaid IP/OP Payments	Total Cost of Care - Medicaid IP/OP Services	Total Medicaid Uncompensated Care	Uninsured IP/OP Revenue
Mackinac Straits Hospital	46.21%	Note 2	Note 1	$ 1,360,857	$ -	$ 59,298	$ 1,420,155	$ 1,930,645	$ 510,490	$ 200,057
Marlette Community (Regional) Hospital	8.34%	Note 2	Note 1	$ 137,753	$ 387,050	$ 139,996	$ 664,799	$ 976,268	$ 311,469	$ -
Marquette General Hospital	14.24%	Note 2	Note 1	$ 13,422,789	$ 5,641,000	$ 3,222,413	$ 22,286,202	$ 25,026,761	$ 2,740,559	$ -
Mary Free Bed Hospital & Rehabilitation Center	10.76%	Note 2	Note 1	$ 2,608,626	$ -	$ 1,474,394	$ 4,083,020	$ 3,885,060	$ (197,960)	$ 25,172
McKenzie Memorial Hospital	13.37%	Note 2	Note 1	$ 302,856	$ 903,495	$ 228,848	$ 1,435,199	$ 2,292,971	$ 857,772	$ 747,946
McLaren Regional Medical Center	8.63%	Note 2	Note 1	$ 17,045,007	$ 6,726,120	$ 2,585,801	$ 26,356,928	$ 26,899,202	$ 542,274	$ 110,396
Mecosta County General Hospital	19.00%	Note 2	Note 1	$ 2,105,542	$ 1,519,106	$ 945,463	$ 4,570,111	$ 4,200,882	$ (369,229)	$ -
Memorial Healthcare	14.47%	Note 2	Note 1	$ 5,759,671	$ 3,362,890	$ 1,035,964	$ 10,158,525	$ 17,032,041	$ 6,873,516	$ 200,879
Memorial Medical Center of West Michigan	19.88%	Note 2	Note 1	$ 3,700,521	$ -	$ 1,677,488	$ 5,378,009	$ 5,729,321	$ 351,312	$ -
Mercy General Health Partners	14.96%	Note 2	Note 1	$ 19,825,033	$ 8,950,594	$ 3,303,332	$ 32,078,959	$ 40,619,165	$ 8,540,206	$ 484,593
Mercy Hospital - Cadillac	14.93%	Note 2	Note 1	$ 2,159,713	$ -	$ 1,828,475	$ 3,988,188	$ 3,642,723	$ (345,465)	$ -
Mercy Hospital - Grayling	14.17%	Note 2	Note 1	$ 1,171,881	$ -	$ 960,686	$ 2,132,567	$ 1,857,370	$ (275,197)	$ -
Mercy Hospital - Port Huron	7.17%	Note 2	Note 1	$ 1,122,423	$ 1,858,668	$ 742,717	$ 3,723,808	$ 4,892,935	$ 1,169,127	$ 128,663
Mercy Memorial Hospital	11.88%	Note 2	Note 1	$ 2,553,101	$ 93,956	$ 1,613,862	$ 4,260,919	$ 5,066,716	$ 805,797	$ 46,293
Metropolitan Hospital - Grand Rapids	14.74%	Note 2	Note 1	$ 3,206,060	$ -	$ 2,944,952	$ 6,151,012	$ 7,339,510	$ 1,188,498	$ 388,597
Mid Michigan Medical Center-Gladwin	11.04%	Note 2	Note 1	$ 504,177	$ -	$ 474,487	$ 978,664	$ 882,536	$ (96,128)	$ 199,686
Mid Michigan Reg. Med. Ctr - Midland	13.06%	Note 2	Note 1	$ 6,465,569	$ -	$ 3,686,583	$ 10,152,152	$ 10,053,254	$ (98,898)	$ 294,000
Mid-Michigan Medical Center-Clare	20.87%	Note 2	Note 1	$ 2,785,787	$ -	$ 1,648,651	$ 4,434,438	$ 4,340,251	$ (94,187)	$ 518,627
Mt. Clemens General Hospital	11.99%	Note 2	Note 1	$ 12,933,933	$ 6,714,248	$ 5,484,294	$ 25,132,475	$ 27,415,582	$ 2,283,107	$ 215,983
Munson Medical Center	10.47%	Note 2	Note 1	$ 11,649,467	$ -	$ 8,044,279	$ 19,693,746	$ 18,771,295	$ (922,451)	$ -
North Oakland Medical Center	21.79%	Note 2	Note 1	$ 5,630,923	$ -	$ 4,896,186	$ 10,527,109	$ 8,461,506	$ (2,065,603)	$ -
North Ottawa Community Hospital	8.22%	Note 2	Note 1	$ 460,421	$ 261,554	$ 437,598	$ 1,159,573	$ 990,831	$ (168,742)	$ 1,000
Northern Michigan Hospitals, Inc.	9.25%	Note 2	Note 1	$ 4,719,022	$ 1,577,547	$ 3,424,513	$ 9,721,082	$ 9,214,321	$ (506,761)	$ 164,165
Oaklawn Hospital	16.87%	Note 2	Note 1	$ 1,103,289	$ -	$ 548,783	$ 1,652,072	$ 1,912,309	$ 260,237	$ -
Oakwood Heritage Hospital	5.89%	Note 2	Note 1	$ 12,020,433	$ 3,669,423	$ 1,161,357	$ 16,851,213	$ 19,181,433	$ 2,330,220	$ 200,242
Oakwood Hospital and Medical Center	19.71%	Note 2	Note 1	$ 43,086,705	$ 17,812,027	$ 12,054,695	$ 72,953,427	$ 84,666,425	$ 11,712,998	$ 929,791
Ontonagon Memorial Hospital	5.79%	Note 2	Note 1	$ 228,164	$ -	$ (3,639)	$ 224,525	$ 287,221	$ 62,696	$ 6,102
Otsego County Memorial Hospital	12.97%	Note 2	Note 1	$ 1,294,474	$ -	$ 765,727	$ 2,060,201	$ 2,030,433	$ (29,768)	$ -
Paul Oliver Memorial Hospital	0.00%	Note 2	Note 3	$ 58,339	$ -	$ 98,396	$ 156,735	$ 266,974	$ 110,239	$ -
Pennock Hospital	7.99%	Note 2	Note 1	$ 1,442,708	$ -	$ 839,197	$ 2,281,905	$ 2,163,455	$ (118,450)	$ 892,210
POH (Pontiac Osteopathic Hospital) Medical Center	15.48%	Note 2	Note 1	$ 2,775,224	$ 6,620,298	$ 3,644,957	$ 13,040,479	$ 14,550,046	$ 1,509,567	$ 1,710,497
Port Huron Hospital	12.74%	Note 2	Note 1	$ 7,871,712	$ 4,824,813	$ 2,299,009	$ 14,995,534	$ 17,493,650	$ 2,498,116	$ 397,422
Portage Health Systems	9.70%	Note 2	Note 1	$ 573,306	$ -	$ 554,396	$ 1,127,702	$ 1,326,991	$ 199,289	$ -
Providence Hospital	10.08%	Note 2	Note 1	$ 7,165,969	$ 9,874,971	$ 6,393,279	$ 23,434,219	$ 29,158,446	$ 5,724,227	$ 3,143,340
Rehabilitation Institute	29.03%	Note 2	Note 1	$ 3,095,677	$ 3,777,424	$ 770,873	$ 7,643,974	$ 8,548,245	$ 904,271	$ 130,183
Scheurer Hospital	5.17%	Note 2	Note 1	$ 161,780	$ -	$ 85,247	$ 247,027	$ 375,468	$ 128,441	$ -
Schoolcraft Memorial Hospital	4.92%	Note 2	Note 1	$ 820,355	$ 161,569	$ 187,005	$ 1,168,929	$ 1,866,510	$ 697,581	$ 569,013
Sheridan Community Hospital	11.26%	Note 2	Note 1	$ 127,949	$ -	$ 229,851	$ 357,800	$ 325,885	$ (31,915)	$ 31,286
Sinai-Grace Hospital **Note 6**	30.06%	Note 2	Note 1	$ 18,680,058	$ 41,100,172	$ 20,185,848	$ 79,966,078	$ 91,410,681	$ 11,444,603	$ -
South Haven Community Hospital	31.25%	Note 2	Note 1	$ 1,180,454	$ 840,101	$ 577,898	$ 2,598,453	$ 2,575,421	$ (23,032)	$ 193,075
Southeast Michigan Surgical Hospital	7.47%	Note 2	Note 1	$ 483,396	$ 383,357	$ 106,134	$ 972,887	$ 1,471,739	$ 498,852	$ -
Spectrum Health **Note 6**	17.96%	Note 2	Note 1	$ 37,839,889	$ -	$ 27,025,186	$ 64,865,075	$ 60,315,283	$ (4,549,792)	$ -
Spectrum Health - Reed City Campus **Note 6**	13.01%	Note 2	Note 1	$ 382,140	$ -	$ 363,478	$ 745,618	$ 813,517	$ 67,899	$ -
St. Francis Hospital	22.92%	Note 2	Note 1	$ 2,891,623	$ -	$ 1,145,246	$ 4,036,869	$ 4,685,403	$ 648,534	$ 470,390
St. John Detroit Riverview Hospital	37.79%	Note 2	Note 1	$ 8,713,235	$ -	$ 7,102,116	$ 15,815,351	$ 13,599,328	$ (2,216,023)	$ 787,265
St. John Hospital and Medical Center	20.79%	Note 2	Note 1	$ 21,903,147	$ 4,730,663	$ 16,602,274	$ 43,236,084	$ 44,460,518	$ 1,224,434	$ 1,152,248
St. John Macomb Hospital	8.44%	Note 2	Note 1	$ 4,013,154	$ 6,170,200	$ 2,811,395	$ 12,994,749	$ 16,081,673	$ 3,086,924	$ 2,039,721
St. John Oakland Hospital	15.17%	Note 2	Note 1	$ 2,656,532	$ 6,002,453	$ 3,315,848	$ 11,974,833	$ 11,933,494	$ (41,339)	$ 1,175,056
St. Joseph Mercy Hospital - Ann Arbor	6.08%	Note 2	Note 1	$ 23,150,453	$ 4,812,651	$ 5,836,813	$ 33,799,917	$ 35,876,068	$ 2,076,151	$ 768,907
St. Joseph Mercy Hospital & Health Services	5.36%	Note 2	Note 1	$ 3,278,268	$ -	$ 1,617,512	$ 4,895,780	$ 4,806,810	$ (88,970)	$ 2,356,608
St. Joseph Mercy Livingston Hospital	10.57%	Note 2	Note 1	$ 3,112,854	$ 403,061	$ 834,080	$ 4,349,995	$ 4,958,850	$ 608,855	$ 265,506
St. Joseph Mercy Oakland	9.53%	Note 2	Note 1	$ 19,437,162	$ 5,905,044	$ 4,675,053	$ 30,017,259	$ 30,908,878	$ 891,619	$ 11,631
St. Mary Mercy Hospital	4.05%	Note 2	Note 1	$ 1,438,081	$ -	$ 676,990	$ 2,115,071	$ 2,483,540	$ 368,469	$ 677,022
St. Mary's Health Care (Grand Rapids)	13.84%	Note 2	Note 1	$ 19,916,013	$ 5,822,242	$ 4,964,167	$ 30,702,422	$ 32,251,360	$ 1,548,938	$ 2,037,139
Sturgis Memorial Hospital	18.40%	Note 2	Note 1	$ 2,987,950	$ 72,192	$ 774,497	$ 3,834,639	$ 4,215,206	$ 380,567	$ 331,764

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
DISPROPORTIONATE SHARE HOSPITAL DATA REPORTING FORM
MEDICAID STATE PLAN RATE YEAR 2005

	2	3	4	5	6	7	8	9	10	11
Hospital Name	Medicaid IP Utilization Rate	Low-Income Utilization Rate	State-Defined DSH Qualification Criteria	Regular IP/OP Medicaid FFS Basic Rate Payments	IP/OP Medicaid MCO Payments	Supplemental/ Enhanced IP/OP Medicaid Payments	Total Medicaid IP/OP Payments	Total Cost of Care - Medicaid IP/OP Services	Total Medicaid Uncompensated Care	Uninsured IP/OP Revenue
Tawas St. Joseph Hospital	10.16%	Note 2	Note 1	$ 621,679	$ 1,478,811	$ 450,335	$ 2,550,825	$ 3,043,644	$ 492,819	$ 247,919
Three Rivers Area Hospital	16.21%	Note 2	Note 1	$ 807,758	$ -	$ 666,471	$ 1,474,229	$ 1,550,520	$ 76,291	$ -
United Memorial Health Center - Spectrum	20.06%	Note 2	Note 1	$ 1,059,535	$ -	$ 619,557	$ 1,679,092	$ 1,710,713	$ 31,621	$ 428,256
University of Michigan Health System	15.80%	Note 2	Note 1	$ 104,105,023	$ 21,029,966	$ 46,534,725	$ 171,669,714	$ 203,076,527	$ 31,406,813	$ 1,594,663
W.A. Foote Memorial Hospital	12.71%	Note 2	Note 1	$ 5,053,392		$ 2,660,717	$ 7,714,109	$ 10,319,769	$ 2,605,660	$ 524,230
West Branch Regional Medical Center	10.89%	Note 2	Note 1	$ 4,037,351	$ 3,751,532	$ 609,288	$ 8,398,171	$ 8,393,965	$ (4,206)	$ 154,202
West Shore Medical Center	12.66%	Note 2	Note 1	$ 788,812	$ -	$ 933,731	$ 1,722,543	$ 1,864,684	$ 142,141	$ -
William Beaumont Hospital - Royal Oak	6.59%	Note 2	Note 1	$ 18,672,996	$ 12,354,688	$ 11,606,535	$ 42,634,219	$ 44,306,927	$ 1,672,708	$ 34,429,472
William Beaumont Hospital - Troy	3.69%	Note 2	Note 1	$ 3,480,560	$ 3,296,582	$ 1,546,973	$ 8,324,115	$ 12,330,912	$ 4,006,797	$ 7,689,806
Zeeland Community Hospital	6.24%	Note 2	Note 1	$ 943,417	$ 1,214	$ 285,864	$ 1,230,495	$ 1,634,895	$ 404,400	$ 163,513
Out-of-State DSH Hospitals										
None										
Institute for Mental Disease										
Caro Center	9.46%	Note 2	Note 1	$ 2,962,112	$ 135,829	$ -	$ 3,097,941	$ 4,904,772	$ 1,806,831	$ 17,831
Kalamazoo Psychiatric Hospital	6.07%	Note 2	Note 1	$ 1,975,738	$ 86,671	$ -	$ 2,062,409	$ 3,069,278	$ 1,006,869	$ 24,726
Kingswood Psychiatric Hospital	59.33%	Note 2	Note 1	$ -	$ 6,031,431	$ 278,005	$ 6,309,436	$ 21,683,680	$ 15,374,244	$ -
Hawthorn	80.30%	Note 2	Note 1	$ 15,836,946	$ 199,579	$ -	$ 16,036,525	$ 17,843,034	$ 1,806,509	$ 1,819
Forensic Facility	0.00%	Note 2	Note 3	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Walter Reuther Psychiatric Hospital	6.06%	Note 2	Note 1	$ 2,262,617	$ 153,739	$ -	$ 2,416,356	$ 3,508,190	$ 1,091,834	$ 66,756

Note 1 - Meets requirement of a Medicaid Utilization rate of at least 1%

Note 2 - Michigan does not require a minimum threshold for LIUR to qualify for DSH payments

Note 3 - Hospital did not meet requirement of a Medicaid Utilization rate of at least 1%

Note 4 - Adequate documentation was not provided to allow for the verification of DSH qualification

Note 5 - State estimated uncompensated and Medicaid costs based upon hospital submitted information

Note 6 - The hospital submitted only summary data to support uninsured costs. No patient detail was submitted, therefore we were unable to verify the accuracy of the summary information.

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
DISPROPORTIONATE SHARE HOSPITAL DATA REPORTING FORM
MEDICAID STATE PLAN RATE YEAR 2005

	12	13	14	15	16	
Hospital Name	Total Applicable Section 1011 Payments	Total cost of IP/OP Care for the Uninsured	Total Uninsured IP/OP Uncompensated Care Cost	Total Annual Uncompensated Care Costs	Disproportionate Share Hospital Payments	Total Submitted IP/OP Care Cost - **Note 5**
Allegan General Hospital	$ -	$ -	$ -	$ 303,296	$ 383,439	$ 6,387,625
Alpena General Hospital	$ -	$ 261,481	$ 228,340	$ (411,272)	$ 4,131,264	$ 12,668,241
Baraga County Memorial Hospital	$ -	$ -	$ -	$ 2,369	$ 457,062	$ 1,236,143
Battle Creek Health System	$ -	$ 2,152,260	$ 1,966,656	$ 3,919,136	$ 401,713	$ 32,030,156
Bay Medical Center	$ -	$ 1,058,436	$ 1,058,436	$ 98,063,411	$ 756,921	$ 17,203,897
Bell Memorial Hospital	$ -	$ -	$ -	$ (20,998)	$ 541,096	$ 5,059,103
Bi-County Community Hospital	$ -	$ 717,952	$ 298,302	$ 3,069,386	$ 15,041	$ 14,233,325
Borgess Hospital	$ -	$ 5,972,022	$ 5,006,382	$ 456,696,512	$ 1,601,604	$ 59,707,482
Botsford General Hospital	$ -	$ 3,862,683	$ 2,778,771	$ 4,230,101	$ 66,098	$ 38,201,684
Bronson Methodist Hospital	$ -	$ 6,708,087	$ 5,832,413	$ 6,202,404	$ 5,300,865	$ 78,338,460
Bronson Vicksburg Hospital	$ -	$ -	$ -	$ 111,661	$ 929	$ 2,058,042
Caro Community Hospital	$ -	$ -	$ -	$ 92,882	$ 153	$ 1,089,387
Carson City Osteopathic Hospital	$ -	$ 712,408	$ 563,300	$ 382,488	$ 1,341,754	$ 6,421,743
Central Michigan Community Hospital	$ -	$ 1,122,709	$ 794,924	$ 939,921	$ 13,788	$ 6,776,530
Charlevoix Area Hospital	$ -	$ 608,575	$ 493,210	$ 511,814	$ 506,536	$ 2,493,652
Cheboygan Memorial Hospital	$ -	$ -	$ -	$ (55,963)	$ 5,810	$ 3,173,622
Chelsea Community Hospital	$ -	$ 272,015	$ 272,015	$ 1,165,414	$ 1,566,555	$ 5,188,315
Children's Hospital of Michigan **Note 6**	$ -	$ -	$ -	$ 14,122,158	$ 17,257,289	$ 186,120,530
Chippewa War Memorial Hospital	$ -	$ 735,665	$ 637,311	$ 2,572,189	$ 8,446	$ 6,808,939
Clinton Memorial Hospital	$ -	$ 206,873	$ 109,523	$ 234,063	$ 713	$ 1,687,165
Community Health Center of Branch County	$ -	$ -	$ -	$ (33,616)	$ 3,071,801	$ 6,747,186
Community Hospital - Watervliet	$ -	$ 825,127	$ 549,930	$ (211,482)	$ 29,240	$ 6,986,835
Cottage Hospital of Grosse Pointe	$ -	$ 391,969	$ 192,694	$ 171,087	$ 140,088	$ 4,882,431
Covenant Medical Center, Inc.	$ -	$ -	$ -	$ (6,114,614)	$ 3,200,911	$ 59,987,602
Crittenton Hospital	$ -	$ -	$ -	$ 1,253,180	$ 24,776	$ 12,485,251
Detroit Receiving Hospital **Note 6**	$ -	$ -	$ -	$ (3,480,171)	$ 17,462,471	$ 158,241,232
Dickinson County Memorial Hospital	$ -	$ 513,393	$ 365,063	$ 3,802,765	$ 2,928,847	$ 6,904,085
Edward W. Sparrow Hospital	$ -	$ 6,140,065	$ 5,609,920	$ 12,627,136	$ 10,503,585	$ 90,562,498
Emma L. Bixby Medical Center	$ -	$ 972,603	$ 972,603	$ 1,890,312	$ 24,370	$ 13,678,842
Garden City Osteopathic Hospital	$ -	$ 2,540,170	$ 2,514,327	$ 2,197,286	$ 59,417	$ 20,922,568
Genesys Regional Medical Center	$ -	$ 4,977,201	$ 4,636,179	$ 7,593,899	$ 10,983,228	$ 49,290,491
Gerber Memorial Hospital **Note 6**	$ -	$ -	$ -	$ 491,125	$ 1,154,796	$ 9,998,563
Grand View Hospital	$ -	$ -	$ -	$ (29,639)	$ 68,884	$ 2,885,019
Gratiot Community Hospital	$ -	$ -	$ -	$ (29,137)	$ 9,222	$ 8,527,413
Hackley Hospital	$ -	$ -	$ -	$ (206,874)	$ 1,399,852	$ 27,350,735
Harper University Hospital **Note 6**	$ -	$ -	$ -	$ 65,269,765	$ 59,297,555	$ 237,518,328
Hayes Green Beach Memorial Hospital	$ -	$ -	$ (310,286)	$ (247,798)	$ 405,668	$ 3,890,932
Healthsource Saginaw	$ -	$ 355,612	$ 263,816	$ 223,377	$ 340,681	$ 2,307,031
Helen Newberry Joy Hospital	$ -	$ 254,802	$ 66,883	$ 1,507,216	$ 919,465	$ 1,580,779
Henry Ford Hospital	$ -	$ 27,236,179	$ 16,992,352	$ 14,356,541	$ 1,070,910	$ 151,194,419
Henry Ford Wyandotte Hospital	$ -	$ 4,492,315	$ 2,013,482	$ 3,688,483	$ 599,818	$ 33,536,509
Herrick Memorial Hospital, Inc.	$ -	$ 209,529	$ 209,529	$ 1,343,484	$ 14,470	$ 6,739,618
Hills & Dales General Hospital	$ -	$ 65,833	$ 48,690	$ 86,058	$ 376	$ 1,436,719
Hillsdale Community Health Center	$ -	$ -	$ (372,534)	$ 269,817	$ 306,227	$ 6,393,649
Holland Community Hospital	$ -	$ 2,444,898	$ 1,868,935	$ 5,227,636	$ 31,550	$ 18,123,642
Hurley Medical Center	$ -	$ 10,401,087	$ 10,239,480	$ 8,237,355	$ 18,089,609	$ 117,412,963
Huron Memorial Hospital	$ -	$ -	$ -	$ 127,282	$ 5,610	$ 2,880,960
Ingham Regional Medical Center	$ -	$ 2,109,418	$ 1,927,771	$ 11,064,671	$ 5,734,697	$ 31,144,908
Ionia County Memorial Hospital	$ -	$ -	$ (186,997)	$ 252,728	$ 399,743	$ 2,763,523
Kalkaska Memorial Health Center	$ -	$ 55,357	$ 51,434	$ 662,213	$ 634,303	$ 1,227,951
Keweenaw Memorial Medical Center	$ -	$ 404,515	$ 319,851	$ 1,323,778	$ 2,520	$ 1,836,761
Lake View Community Hospital	$ -	$ 956,399	$ 612,495	$ 1,626,988	$ 965	$ 3,497,923
Lakeland Hospital - St. Joseph	$ -	$ -	$ -	$ 43,784,255	$ 1,479,025	$ 36,929,592
Lakeshore Community Hospital	$ -	$ -	$ -	$ (37,840)	$ 10,783	$ 2,402,143
Lapeer Regional Hospital	$ -	$ 1,967,234	$ 1,702,334	$ 1,430,535	$ 61,147	$ 8,931,187

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
DISPROPORTIONATE SHARE HOSPITAL DATA REPORTING FORM
MEDICAID STATE PLAN RATE YEAR 2005

Hospital Name	12 Total Applicable Section 1011 Payments	13 Total cost of IP/OP Care for the Uninsured	14 Total Uninsured IP/OP Uncompensated Care Cost	15 Total Annual Uncompensated Care Costs	16 Disproportionate Share Hospital Payments	Total Submitted IP/OP Care Cost - **Note 5**
Mackinac Straits Hospital	$ -	$ 403,729	$ 203,672	$ 714,162	$ 464,731	$ 852,359
Marlette Community (Regional) Hospital	$ -	$ -	$ -	$ 311,469	$ 755	$ 2,125,313
Marquette General Hospital	$ -	$ -	$ -	$ 2,740,559	$ 2,776,357	$ 20,598,975
Mary Free Bed Hospital & Rehabilitation Center	$ -	$ 172,422	$ 147,250	$ (50,710)	$ 1,921	$ 4,760,848
McKenzie Memorial Hospital	$ -	$ -	$ (747,946)	$ 109,826	$ 3,194	$ 2,080,434
McLaren Regional Medical Center	$ -	$ 843,150	$ 732,754	$ 1,275,028	$ 12,170,531	$ 29,830,301
Mecosta County General Hospital	$ -	$ -	$ -	$ (369,229)	$ 1,132,713	$ 6,011,483
Memorial Healthcare	$ -	$ 1,517,146	$ 1,316,267	$ 8,189,783	$ 21,434	$ 9,017,759
Memorial Medical Center of West Michigan	$ -	$ 909,916	$ 909,916	$ 1,261,228	$ 1,115,301	$ 8,812,441
Mercy General Health Partners	$ -	$ 3,072,355	$ 2,587,762	$ 11,127,968	$ 2,284,241	$ 25,512,491
Mercy Hospital - Cadillac	$ -	$ -	$ -	$ (345,465)	$ 14,828	$ 6,821,298
Mercy Hospital - Grayling	$ -	$ -	$ -	$ (275,197)	$ 1,015,330	$ 6,021,687
Mercy Hospital - Port Huron	$ -	$ 1,075,377	$ 946,714	$ 2,115,841	$ 12,820	$ 7,697,372
Mercy Memorial Hospital	$ -	$ 1,809,506	$ 1,763,213	$ 2,569,010	$ 12,833	$ 9,721,799
Metropolitan Hospital - Grand Rapids	$ -	$ 2,336,758	$ 1,948,161	$ 3,136,659	$ 1,183,288	$ 32,503,217
Mid Michigan Medical Center-Gladwin	$ -	$ 456,655	$ 256,969	$ 160,841	$ 434,347	$ 2,747,180
Mid Michigan Reg. Med. Ctr - Midland	$ -	$ 2,894,162	$ 2,600,162	$ 2,501,264	$ 1,987,379	$ 21,368,676
Mid-Michigan Medical Center-Clare	$ -	$ 1,098,472	$ 579,845	$ 485,658	$ 1,330,207	$ 8,268,254
Mt. Clemens General Hospital	$ -	$ 3,739,881	$ 3,523,898	$ 5,807,005	$ 5,314,058	$ 40,811,652
Munson Medical Center	$ -	$ -	$ -	$ (922,451)	$ 1,431,062	$ 30,498,381
North Oakland Medical Center	$ -	$ -	$ -	$ (2,065,603)	$ 375,515	$ 29,224,724
North Ottawa Community Hospital	$ -	$ 302,327	$ 301,327	$ 132,585	$ 2,875	$ 3,641,053
Northern Michigan Hospitals, Inc.	$ -	$ 2,336,624	$ 2,172,459	$ 1,665,698	$ 1,412,400	$ 13,763,378
Oaklawn Hospital	$ -	$ -	$ -	$ 260,237	$ 13,174	$ 5,440,039
Oakwood Heritage Hospital	$ -	$ 2,727,573	$ 2,527,331	$ 4,857,551	$ 1,005,235	$ 26,131,254
Oakwood Hospital and Medical Center	$ -	$ 9,214,250	$ 8,284,459	$ 19,997,457	$ 1,538,790	$ 89,205,743
Ontonagon Memorial Hospital	$ -	$ 8,050	$ 1,948	$ 64,644	$ 763,198	$ 1,406,936
Otsego County Memorial Hospital	$ -	$ -	$ -	$ (29,768)	$ 729,277	$ 4,931,300
Paul Oliver Memorial Hospital	$ -	$ -	$ -	$ 110,239	$ 208,816	$ 679,964
Pennock Hospital	$ -	$ 1,568,522	$ 676,312	$ 557,862	$ 1,138,016	$ 6,621,195
POH (Pontiac Osteopathic Hospital) Medical Center	$ -	$ 5,013,403	$ 3,302,906	$ 4,812,473	$ 199,459	$ 27,335,576
Port Huron Hospital	$ -	$ 1,598,494	$ 1,201,072	$ 3,699,188	$ 94,538	$ 15,953,655
Portage Health Systems	$ -	$ -	$ -	$ 199,289	$ 449,620	$ 3,933,369
Providence Hospital	$ -	$ 6,646,862	$ 3,503,522	$ 9,227,749	$ 1,054,782	$ 49,685,883
Rehabilitation Institute	$ -	$ 392,682	$ 262,499	$ 1,166,770	$ 206,895	$ 14,833,999
Scheurer Hospital	$ -	$ 11,682	$ 11,682	$ 140,123	$ 539	$ 1,424,084
Schoolcraft Memorial Hospital	$ -	$ 613,812	$ 44,799	$ 742,380	$ 856,307	$ 2,313,184
Sheridan Community Hospital	$ -	$ 243,128	$ 211,842	$ 179,927	$ 1,631	$ 2,046,844
Sinai-Grace Hospital **Note 6**	$ -	$ -	$ -	$ 11,444,603	$ 3,677,875	$ 147,190,195
South Haven Community Hospital	$ -	$ 1,393,003	$ 1,199,928	$ 1,176,896	$ 3,474,034	$ 6,156,086
Southeast Michigan Surgical Hospital	$ -	$ -	$ -	$ 498,852	$ 703	$ 836,424
Spectrum Health **Note 6**	$ -	$ -	$ -	$ (4,549,792)	$ 2,247,126	$ 146,276,644
Spectrum Health - Reed City Campus **Note 6**	$ -	$ -	$ -	$ 67,899	$ 2,054	$ 3,070,047
St. Francis Hospital	$ -	$ 1,883,586	$ 1,413,196	$ 2,061,730	$ 11,682	$ 7,477,923
St. John Detroit Riverview Hospital	$ -	$ 6,228,435	$ 5,441,170	$ 3,225,147	$ 2,394,007	$ 62,235,059
St. John Hospital and Medical Center	$ -	$ 11,568,051	$ 10,415,803	$ 11,640,237	$ 14,423,711	$ 93,681,305
St. John Macomb Hospital	$ -	$ 3,275,497	$ 1,235,776	$ 4,322,700	$ 1,394	$ 20,317,580
St. John Oakland Hospital	$ -	$ 2,106,700	$ 931,644	$ 890,305	$ 127,125	$ 21,328,790
St. Joseph Mercy Hospital - Ann Arbor	$ -	$ 11,113,315	$ 10,344,408	$ 12,420,559	$ 6,519,601	$ 40,884,226
St. Joseph Mercy Hospital & Health Services	$ -	$ 4,081,992	$ 1,725,384	$ 1,636,414	$ 6,910	$ 17,040,009
St. Joseph Mercy Livingston Hospital	$ -	$ 1,543,270	$ 1,277,764	$ 1,886,619	$ 422,985	$ 5,345,879
St. Joseph Mercy Oakland	$ -	$ 1,046,386	$ 1,034,755	$ 1,926,374	$ 38,457	$ 26,777,822
St. Mary Mercy Hospital	$ -	$ 31,383,944	$ 30,706,922	$ 31,075,391	$ 3,409	$ 8,477,247
St. Mary's Health Care (Grand Rapids)	$ -	$ 2,679,408	$ 642,269	$ 2,191,207	$ 1,765,642	$ 51,110,151
Sturgis Memorial Hospital	$ -	$ 906,698	$ 574,934	$ 955,501	$ 1,804,925	$ 4,895,443

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
DISPROPORTIONATE SHARE HOSPITAL DATA REPORTING FORM
MEDICAID STATE PLAN RATE YEAR 2005

	12	13	14	15	16	
Hospital Name	Total Applicable Section 1011 Payments	Total cost of IP/OP Care for the Uninsured	Total Uninsured IP/OP Uncompensated Care Cost	Total Annual Uncompensated Care Costs	Disproportionate Share Hospital Payments	Total Submitted IP/OP Care Cost - Note 5
Tawas St. Joseph Hospital	$ -	$ 834,110	$ 586,191	$ 1,079,010	$ 577,500	$ 4,406,090
Three Rivers Area Hospital	$ -	$ -	$ -	$ 76,291	$ 3,273,738	$ 6,699,649
United Memorial Health Center - Spectrum	$ -	$ 931,925	$ 503,669	$ 535,290	$ 8,474	$ 4,928,647
University of Michigan Health System	$ -	$ 16,388,713	$ 14,794,050	$ 46,200,863	$ 42,716,857	$ 155,429,527
W.A. Foote Memorial Hospital	$ -	$ 3,990,850	$ 3,466,620	$ 6,072,280	$ 1,871,001	$ 50,139,190
West Branch Regional Medical Center	$ -	$ 779,853	$ 625,651	$ 621,445	$ 1,261,646	$ 5,781,197
West Shore Medical Center	$ -	$ -	$ -	$ 142,141	$ 1,597,434	$ 6,454,681
William Beaumont Hospital - Royal Oak	$ -	$ 45,894,383	$ 11,464,911	$ 13,137,619	$ 495,644	$ 94,254,560
William Beaumont Hospital - Troy	$ -	$ 11,450,147	$ 3,760,341	$ 7,767,138	$ 8,340	$ 9,485,124
Zeeland Community Hospital	$ -	$ 721,180	$ 557,667	$ 962,067	$ 1,277	$ 1,954,539
Out-of-State DSH Hospitals						
None						
Institute for Mental Disease						
Caro Center	$ -	$ 23,758,832	$ 23,741,001	$ 25,547,832	$ 28,503,564	$ 31,481,926
Kalamazoo Psychiatric Hospital	$ -	$ 23,071,546	$ 23,046,820	$ 24,053,689	$ 21,104,005	$ 22,293,692
Kingswood Psychiatric Hospital	$ -	$ -	$ -	$ 15,374,244	$ 744,242	$ 8,917,736
Hawthorn	$ -	$ 989,889	$ 988,070	$ 2,794,579	$ 7,101,633	$ 18,445,088
Forensic Facility	$ -	$ -	$ -	$ -	$ 45,361,414	$ 45,885,044
Walter Reuther Psychiatric Hospital	$ -	$ 31,859,558	$ 31,792,802	$ 32,884,636	$ 31,018,960	$ 33,810,182

Note 1 - Meets requirement of a Medicaid Utilization rate of at least 1%

Note 2 - Michigan does not require a minimum threshold for LIUR to qualify for DSH payments

Note 3 - Hospital did not meet requirement of a Medicaid Utilization rate of at least 1%

Note 4 - Adequate documentation was not provided to allow for the verification of DSH qualification

Note 5 - State estimated uncompensated and Medicaid costs based upon hospital submitted information

Note 6 - The hospital submitted only summary data to support uninsured costs. No patient detail was submitted, therefore we were unable to verify the accuracy of the summary information.

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
SUMMARY OF FINDINGS

Finding 1 –

Criteria
Social Security Act section 1923(d) requires that, unless exempt, a hospital must have at least two obstetricians, or two physicians if the hospital is located in a rural area, who have staff privileges at the hospital, as well as, a Medicaid inpatient utilization rate (MIUR) of not less than 1 percent to qualify as a disproportionate share hospital.

Condition
One of the 126 hospitals that received DSH payments in MSP rate year 2005 did not document having at least two obstetricians or two physicians if the hospital is located in a rural area, who have staff privileges at the hospital. Three of the 126 hospitals that received DSH payments in MSP rate year 2005 did not have a Medicaid inpatient utilization rate exceeding 1 percent to qualify as a disproportionate share hospital.

Recommendation
We recommend that MDCH implement a review process to ensure hospitals that receive DSH payments maintain documentation supporting the qualification requirements to be deemed as a disproportionate share hospital.

Finding 2 –

Criteria
Social Security Act section 1923(g)(1)(A) specified that DSH payments to a hospitals shall not exceed the cost incurred (net of the payments received) during the MSP rate year. Section 42 CFR Part 455.304(d)(2) further clarified that DSH payments made to each qualifying hospital shall comply with the hospital-specific DSH payment limit.

Condition
We found that 49 hospitals in Michigan received DSH payments in MSP rate year 2005 in excess of the hospital-specific DSH limit. Except for the 26 hospitals that did not provide adequate documentation to calculate the hospital-specific DSH limit, we found that 23 hospitals received DSH payments exceeding their hospital-specific DSH payment limits calculated based on the DSH Rule.

It is notable that Michigan hospitals were generally very cooperative during the audit process. A majority of hospitals were able to provide detailed patient specific data necessary to fully document their hospital specific DSH limits. Some hospitals were not able to provide this detailed information due to data systems limitations and due to the length of time that expired between the generation of the original data and the audit data request. It is also notable that,

though unable to fully comply with the detailed audit data request, this latter group of hospitals were able to provide the data necessary to support the aggregated uninsured information that was reported to the State and which the State in-turn used in calculating the hospital specific DSH limits.

Recommendation
We recommend that MDCH utilize the findings noted during this and subsequent audits when calculating hospital-specific DSH payment limits for the MSP rate year 2011 and thereafter. MDCH should make any necessary adjustments to the calculation of DSH limits for those hospitals that routinely exceed the hospital specific DSH limit based upon verified numbers.

Finding 3 –

Criteria
Social Security Act section 1923(g)(1)(A) states that with respect to a disproportionate share hospital, the DSH payment limit is subject to uncompensated costs, which include costs incurred (net of payments) during the MSP rate year for furnishing hospital services to individuals who either are eligible for medical assistance under the State Plan or have no health insurance (or other source of third-party coverage) for services provided during the MSP rate year.

Additionally, Section 42 CFR Part 455.304(d)(3) requires that 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 are eligible for inclusion in the calculation of the hospital-specific DSH payment limit.

Condition
We identified 19 hospitals for MSP rate year 2005 that included charges and consequently costs for furnishing hospital services to individuals who had insurance or other third-party coverage as uninsured charges. The CMS-approved MSP effective for the period reviewed allowed "costs for services to indigent patients" to be included in the calculation of the hospital-specific limit. The MSP did not define an indigent patient. The MSP does not comply with the Social Security Act, which states that payment adjustments are for "...furnishing hospital services by the hospital to individuals who...have no health insurance (or other source of third party coverage) for services provided during the year."

Recommendation
We recommend that MDCH continue to educate hospitals regarding the definition of "uninsured costs" under the Final DSH rule. MDCH must ensure that 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 Social Security Act are eligible for inclusion in the calculation of the hospital-specific disproportionate share limit payment limit.

Finding 4 –

Criteria
Social Security Act section 1923(g)(1)(A) specifies that the hospital-specific DSH payment limit should be subject to costs net of all non-DSH section payments received under Title XIX of the Social Security Act. Section 42 CFR Part 455.304(d)(4) echoes this requirement and states that all Medicaid payments should be applied against uncompensated care costs for the purposes of hospital-specific limit calculation.

Condition
The CMS-approved 2005 State MSP is silent as to the costs eligible for the hospital-specific DSH payment limit. As a result, MDCH did not apply all payments made on behalf of Medicaid eligible individuals in the calculation of the hospital-specific DSH payment limit.

Recommendation
We recommend that MDCH include the following payments when calculating the hospital-specific limit:

- Medicaid fee-for-service rate payments and all supplemental/enhanced payments made by Medicaid agencies from other states, and
- Medicare and other payer payments for furnishing inpatient and outpatient hospital services to Medicaid-eligible patients.

MDCH should also:

- Require disproportionate share hospitals to report all Medicaid payments, including Medicare payments for dual-eligible patients, and
- Revise its hospital-specific DSH payment limit calculation model to include these payments, as required in the Social Security Act and the DSH Rule.

Finding 5 –

Criteria
Section 42 CFR Part 455.304(d)(5) requires that states separately document and retain a record of the following: all of costs under the Medicaid program; claimed expenditures under the Medicaid program; uninsured inpatient and outpatient hospital service costs in determining DSH payments; and any payments made on behalf of the uninsured.

Condition
In its provider agreement with disproportionate share hospitals, MDCH required these hospitals to retain all necessary documents for audits under the Medicaid programs including the DSH programs. We found that 38 hospitals in MSP rate year 2005 did not provide information or records 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; and/or payments made on behalf of the uninsured from payment adjustments.

As noted in Finding 2, the Michigan hospitals were generally very cooperative during the audit process. A majority of hospitals were able to provide detailed patient specific data necessary to fully document their hospital specific DSH limits. Some hospitals were not able to provide this detailed information due to data systems limitations and due to the length of time that expired between the generation of the original data and the audit data request. It is also notable that, though unable to fully comply with the detailed audit data request, this latter group of hospitals were able to provide the data necessary to support the aggregated uninsured information that was reported to the State and which the State in-turn used in calculating the hospital specific DSH limits.

Recommendation

We recommend that MDCH implement periodic monitoring procedures to ensure disproportionate share hospitals maintain complete and accurate data and records to support 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 42 CFR Part 455.304(d).

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
DISPROPORTIONATE SHARE PROGRAM VERIFICATIONS

The agreed upon procedures enumerated in **Exhibits II, III, and IV,** were performed to assist the Michigan Department of Community Health in evaluating its compliance with the Social Security Act (the Act) as it relates to Medicaid Disproportionate Share Hospital (DSH) payments. The procedures were also performed to assess the Department's compliance with the six Verifications required under 42 CFR §455.304(d). Our findings relating to each Verification are shown below:

Verification 1

Our procedures disclosed that three (3) hospital in MSP rate year 2005 did not meet the qualification requirements (Medicaid Inpatient Utilization Rate of at least 1% defined in Social Security Act section 1923(d), but received DSH payments.

Because one hospital did not provide adequate documentation to support two obstetricians on staff, we were unable to determine whether these two hospitals met the qualification requirements set forth in Social Security Act section 1923(d).

Our procedures disclosed that hospitals with Indigent Care Agreements (ICA), a qualification for the ICA DSH pool, were not permitted to retain the ICA DSH payment.

Except for the effects discussed in the preceding paragraphs and except for the matters we might have discovered had we been able to apply adequate procedures to the one hospital that did not provide documentation, each hospital that qualifies for a DSH payment in Michigan is allowed to retain that payment received in accordance with 42 CFR §455.304 (d)(1) relating to the Medicaid Program's DSH Rule.

Verification 2

Our procedures disclosed that none of the hospitals exceeded their hospital-specific DSH payment limit, computed based on the Centers for Medicare and Medicaid Services (CMS) approved MSP effective in MSP rate year 2005. However, the methodology for calculating the hospital-specific limit as specified in that MSP is not in compliance with the final DSH Rule effective as of January 19, 2009. Specifically, the 2005 MSP allowed the costs of care for providing hospital services to "indigent" persons who have insufficient insurance or have exhausted other third-party coverage in the calculation of hospital-specific DSH payment limits.

Additionally, not all payments that a hospital received for providing care to Medicaid-eligible patients were applied against the cost of care for the purpose of calculating hospital-specific

DSH payment limits. The DSH Rule states that only uncompensated care cost for furnishing hospital services to Medicaid-eligible individuals and individuals with no third-party coverage are eligible for inclusion in the calculation of the hospital-specific DSH payment limit. As a result, 49 hospitals in MSP rate year 2005 received DSH payments that exceeded their hospital-specific DSH payment limits, calculated based on the final DSH Rule.

Because 26 of the 49 hospitals noted in the preceding paragraph did not provide adequate documentation, we were unable to determine whether these 26 hospitals comply with the hospital-specific DSH payment limit in accordance with 42 CFR §455.304 (d)(2) relating to the Medicaid Program's DSH Rule.

Except for the effects discussed in the preceding paragraphs, DSH payments made to each qualifying hospital comply with the hospital-specific DSH payment limit in accordance with 42 CFR §455.304 (d)(2) relating to the Medicaid Program's DSH Rule.

Verification 3

Our procedures disclosed that the 2005 Michigan MSP, which was approved by CMS, allowed the inclusion of uncompensated costs for providing inpatient and outpatient hospitals services to "indigent" persons who have insufficient insurance or have exhausted other third-party coverage in the calculation of hospital-specific DSH payment limits. The 2005 Michigan MSP, as approved, was not in compliance with the final DSH Rule as effective on January 19, 2009. We tested the uninsured data provided by 35 hospitals and found that 19 of these 35 hospitals included patients with insurance or third-party coverage in their self-reported uninsured data.

Because of the effects discussed in the preceding paragraph, management did not include 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 as eligible costs in the calculation of the hospital-specific DSH payment limit in accordance with 42 CFR §455.304 (d)(3) relating to the Medicaid Program's DSH Rule.

Verification 4

Our procedures disclosed that the CMS-approved 2005 Michigan MSP is silent on the treatment of other Medicaid payments such as those made by Medicaid agencies from other states or Medicare payments for dual-eligible patients. As a result, Medicaid payments from out-of-state Medicaid agencies, certain Medicaid supplemental or enhanced payments, and Medicare payments for dual-eligible patients that disproportionate share hospitals received for providing inpatient and outpatient hospitals services to Medicaid-eligible individuals which were in excess of the Medicaid incurred costs of such services, were not 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.

Because of the effects discussed in the preceding paragraph, not all Medicaid payments, that 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 in accordance with 42 CFR §455.304 (d)(4) relating to the Medicaid Program's DSH Rule.

Verification 5

Our procedures disclosed that the responsibility for retention of documentation was accepted by the hospitals under their provider agreements with the State. Thirty-eight (38) hospitals did not retain or make available to us during the course of this engagement, information or records of their inpatient and outpatient hospital service costs under the Medicaid program; claimed expenditures under the Medicaid program; or uninsured inpatient and outpatient hospital service costs in determining payment adjustments under 42 CFR §455.304; and any payments made on behalf of the uninsured from payment adjustments.

Except for the effects discussed in the preceding paragraph, management separately documented and retained information and records of costs and payments related to the DSH program in accordance with 42 CFR §455.304 (d)(5) relating to the Medicaid Program's DSH Rule.

Verification 6

Our procedures disclosed that the information specified in the DSH Rule includes a description of the methodology for calculating each hospital's payment limit under Section 1923(g)(1) of the Social Security Act, and included in the description of the methodology, the State has specified how it 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.

Management included in the information and records it retained a description of the methodology for calculating each hospital's DSH payment limit and definitions of incurred inpatient and outpatient costs in accordance with 42 CFR §455.304 (d)(6) relating to the Medicaid Program's DSH Rule.