STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
Lansing, Michigan

DISPROPORTIONATE SHARE PROGRAM
AGREED UPON PROCEDURES
Medicaid State Plan Rate Year September 30, 2006

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, 2005 through September 30, 2006. 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 affect 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 affect 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.