STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
Lansing, Michigan

DISPROPORTIONATE SHARE PROGRAM
AGREED UPON PROCEDURES
Medicaid State Plan Rate Year September 30, 2007

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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, 2006 through September 30, 2007. 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 VI 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 resulting from these procedures are described in **Exhibit VI.**

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 #3by 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 that provides services to low-income patients with special needs who do not have other coverage.

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 2005.

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 and/or will certify public expenditures (CPE) 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 2007, the State did compare the DSH payments of each individual hospital to uncompensated care costs (from 2004, 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 2007

		1	2	3	4	5	6	7	8	9	10
Provider Number	Provider Name	State Estimated Hospital-Specific DSH Limit	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
23-1328	Allegan General Hospital	$ 6,203,492	25.74%	Note 1	Note 2	$ 640,769	$ 1,501,932	$ 550,850	$ 2,693,551	$ 4,612,135	$ 1,918,584
23-0036	Alpena General Hospital	$ 4,474,363	12.39%	Note 1	Note 2	$ 11,898,918	$ 3,423,923	$ 1,364,808	$ 16,687,649	$ 49,272,210	$ 32,584,561
23-0075	Battle Creek Health System	$ 14,254,474	18.07%	Note 1	Note 2	$ 26,524,852	$ -	$ 3,841,612	$ 30,366,464	$ 43,250,534	$ 12,884,070
23-0041	Bay Medical Center	$ 6,947,240	11.30%	Note 1	Note 2	$ 20,417,634	$ 7,826,057	$ 3,115,544	$ 31,359,235	$ 147,015,198	$ 115,655,963
23-1321	Bell Memorial Hospital	$ 693,508	16.72%	Note 1	Note 4	$ 559,602	$ -	$ 531,750	$ 1,091,352	$ 1,361,802	$ 270,450
23-0204	Bi-County Community Hospital	$ 5,870,384	7.99%	Note 1	Note 2	$ 2,121,955	$ 3,575,454	$ 2,025,945	$ 7,723,354	$ 11,352,403	$ 3,629,049
23-0089	Bon Secours Hospital	$ 4,786,505	6.39%	Note 1	Note 2	$ 1,897,796	$ -	$ 1,144,649	$ 3,042,445	$ 3,054,201	$ 11,756
23-0117	Borgess Hospital	$ 23,023,141	15.29%	Note 1	Note 2	$ 33,299,111	$ 11,294,654	$ 7,209,031	$ 51,802,796	$ 53,634,457	$ 1,831,661
23-0151	Botsford General Hospital	$ 18,862,232	11.06%	Note 1	Note 2	$ 22,443,266	$ 7,523,992	$ 5,048,781	$ 35,016,039	$ 34,027,825	$ (988,214)
23-0017	Bronson Methodist Hospital	$ 24,595,590	24.77%	Note 1	Note 2	$ 30,919,376	$ 18,797,828	$ 15,018,116	$ 64,735,320	$ 122,751,469	$ 58,016,149
23-0190	Bronson Vicksburg Hospital	$ 867,435	0.00%	Note 1	Note 3	$ 80,170	$ 126,962	$ 167,145	$ 374,277	$ 540,134	$ 165,857
23-1329	Caro Community Hospital	$ 1,433,056	5.46%	Note 1	Note 2	$ 124,198	$ 239,758	$ 90,849	$ 454,805	$ 391,806	$ (62,999)
23-0208	Carson City Osteopathic Hospital	$ 3,923,673	25.14%	Note 1	Note 2	$ 746,093	$ -	$ 433,938	$ 1,180,031	$ 1,140,849	$ (39,182)
23-0080	Central Michigan Community Hospital	$ 1,064,488	13.56%	Note 1	Note 2	$ 5,391,945	$ 386,221	$ 2,279,101	$ 8,057,267	$ 8,209,625	$ 152,358
23-1322	Charlevoix Area Hospital	$ 895,563	15.51%	Note 1	Note 2	$ 2,599,409	$ 329,244	$ 648,279	$ 3,576,932	$ 4,433,912	$ 856,980
23-0034	Cheboygan Memorial Hospital	$ 469,127	15.38%	Note 1	Note 2	$ 2,069,540	$ -	$ 1,713,644	$ 3,783,184	$ 3,423,383	$ (359,801)
23-0259	Chelsea Community Hospital	$ 2,356,173	7.42%	Note 1	Note 2	$ 983,833	$ 1,562,813	$ 130,199	$ 2,676,845	$ 3,977,139	$ 1,300,294
23-3300	Children's Hospital of Michigan	$ 16,448,824	62.38%	Note 1	Note 2	$ 46,990,536	$ 34,672,886	$ 50,839,294	$ 132,502,716	$ 163,507,569	$ 31,004,853
23-0239	Chippewa War Memorial Hospital	$ 1,863,041	15.50%	Note 1	Note 2	$ 5,656,504	$ 1,025,119	$ 971,918	$ 7,653,541	$ 7,996,433	$ 342,892
23-1326	Clinton Memorial Hospital	$ 1,040,336	4.47%	Note 1	Note 2	$ 140,481	$ -	$ 272,473	$ 412,954	$ 223,099	$ (189,855)
23-0022	Community Health Center of Branch County	$ 3,200,883	14.11%	Note 1	Note 2	$ 1,743,237	$ -	$ 1,371,974	$ 3,115,211	$ 7,772,307	$ 4,657,096
23-0078	Community Hospital - Watervliet	$ 2,328,597	9.81%	Note 1	Note 2	$ 1,881,844	$ 817,601	$ 556,846	$ 3,256,291	$ 5,227,446	$ 1,971,155
23-0070	Covenant Medical Center, Inc.	$ 2,477,639	23.00%	Note 1	Note 2	$ 16,091,015	$ 19,442,051	$ 10,679,707	$ 46,212,773	$ 46,355,233	$ 142,460
23-0254	Crittenton Hospital	$ 6,525,764	3.90%	Note 1	Note 2	$ 4,339,199	$ 579,432	$ 1,220,202	$ 6,138,833	$ 15,350,879	$ 9,212,046
23-0273	Detroit Receiving Hospital	$ 40,886,011	39.92%	Note 1	Note 2	$ 47,610,253	$ 29,472,431	$ 22,034,693	$ 99,117,377	$ 115,603,782	$ 16,486,405
23-0055	Dickinson County Memorial Hospital	$ 2,327,893	7.51%	Note 1	Note 2	$ 4,727,280	$ 1,439,011	$ 739,722	$ 6,906,013	$ 7,579,202	$ 673,189
23-0230	Edward W. Sparrow Hospital	$ 36,768,123	16.30%	Note 1	Note 2	$ 18,565,321	$ 45,041,816	$ 15,346,545	$ 78,953,682	$ 73,770,393	$ (5,183,289)
23-0005	Emma L. Bixby Medical Center	$ 4,036,814	14.91%	Note 1	Note 2	$ 4,092,945	$ 2,733,344	$ 1,349,807	$ 8,176,096	$ 9,781,635	$ 1,605,539
23-0244	Garden City Osteopathic Hospital	$ 13,876,356	13.96%	Note 1	Note 2	$ 10,887,909	$ 2,558,768	$ 3,134,426	$ 16,581,103	$ 16,598,983	$ 17,880
23-0197	Genesys Regional Medical Center	$ 11,134,833	12.47%	Note 1	Note 2	$ 32,552,665	$ 15,335,755	$ 12,959,219	$ 60,847,639	$ 67,273,886	$ 6,426,247
23-0106	Gerber Memorial Hospital	$ 4,616,563	32.43%	Note 1	Note 2	$ 1,243,787	$ 788,970	$ 961,084	$ 2,993,841	$ 4,325,543	$ 1,331,702
23-1333	Grand View Hospital	$ 1,142,340	16.58%	Note 1	Note 2	$ 408,115	$ -	$ 340,069	$ 748,184	$ 989,580	$ 241,396
23-0030	Gratiot Community Hospital	$ 1,621,273	11.97%	Note 1	Note 2	$ 2,207,214	$ -	$ 1,412,026	$ 3,619,240	$ 3,590,600	$ (28,640)
23-0066	Hackley Hospital	$ 10,023,349	19.50%	Note 1	Note 2	$ 4,186,504	$ 9,182,499	$ 2,593,280	$ 15,962,283	$ 19,081,011	$ 3,118,728
23-0104	Harper University Hospital	$ 65,182,224	45.57%	Note 1	Note 2	$ 67,359,010	$ 43,870,167	$ 31,155,203	$ 142,384,380	$ 198,669,099	$ 56,284,719
23-1327	Hayes Green Beach Memorial Hospital	$ 1,116,094	21.83%	Note 1	Note 2	$ 537,697	$ -	$ 463,631	$ 1,001,328	$ 1,155,549	$ 154,221
23-0275	Healthsource Saginaw	$ 459,484	25.96%	Note 1	Note 2	$ 218,162	$ -	$ 130,980	$ 349,142	$ 373,296	$ 24,154
23-1304	Helen Newberry Joy Hospital	$ 949,216	4.92%	Note 1	Note 2	$ 174,364	$ 368,782	$ 126,366	$ 669,512	$ 951,261	$ 281,749
23-0053	Henry Ford Hospital	$ 69,927,269	18.07%	Note 1	Note 2	$ 24,456,096	$ -	$ 31,616,184	$ 56,072,280	$ 41,389,576	$ (14,682,704)
23-0146	Henry Ford Wyandotte Hospital	$ 12,620,747	12.24%	Note 1	Note 2	$ 1,057,358	$ 8,048,059	$ 2,792,439	$ 11,897,856	$ 13,156,738	$ 1,258,882
23-1334	Herrick Memorial Hospital, Inc.	$ 3,299,283	30.41%	Note 1	Note 2	$ 548,605	$ -	$ 391,225	$ 939,830	$ 1,103,422	$ 163,592
23-1316	Hills & Dales General Hospital	$ 835,354	5.88%	Note 1	Note 2	$ 142,194	$ 550,269	$ 99,328	$ 791,791	$ 1,693,550	$ 901,759
23-0037	Hillsdale Community Health Center	$ 2,990,578	16.08%	Note 1	Note 2	$ 7,843,509	$ 10,404,348	$ 815,161	$ 19,063,018	$ 28,181,940	$ 9,118,922
23-0072	Holland Community Hospital	$ 6,084,655	15.87%	Note 1	Note 2	$ 3,312,685	$ 4,112,208	$ 1,875,129	$ 9,300,022	$ 22,062,015	$ 12,761,993
23-0132	Hurley Medical Center	$ 25,688,651	39.46%	Note 1	Note 2	$ 55,853,749	$ 44,812,620	$ 24,195,459	$ 124,861,828	$ 131,493,432	$ 6,631,604
23-0118	Huron Memorial Hospital	$ 1,161,154	16.67%	Note 1	Note 2	$ 619,689	$ -	$ 519,828	$ 1,139,517	$ 1,326,223	$ 186,706
23-0277	Huron Valley - Sinai Hospital	$ 983,353	7.97%	Note 1	Note 2	$ 5,371,652	$ 2,167,192	$ 1,487,647	$ 9,026,491	$ 13,886,737	$ 4,860,246
23-0167	Ingham Regional Medical Center	$ 13,256,818	12.12%	Note 1	Note 2	$ 21,565,859	$ 10,527,133	$ 5,137,053	$ 37,230,045	$ 51,142,073	$ 13,912,028
23-1331	Ionia County Memorial Hospital	$ 1,065,257	5.90%	Note 1	Note 2	$ 186,135	$ -	$ 554,835	$ 740,970	$ 398,409	$ (342,561)
23-1301	Kalkaska Memorial Health Center	$ 910,005	2.52%	Note 1	Note 2	$ 1,055,380	$ 78,765	$ 366,281	$ 1,500,426	$ 1,921,971	$ 421,545
23-1319	Keweenaw Memorial Medical Center	$ 1,868,316	10.04%	Note 1	Note 2	$ 314,874	$ 442,222	$ 204,455	$ 961,551	$ 1,822,727	$ 861,176
23-1332	Lake View Community Hospital	$ 2,577,480	2.82%	Note 1	Note 2	$ 298,110	$ -	$ 520,899	$ 819,009	$ 702,549	$ (116,460)
23-0021	Lakeland Hospital - St. Joseph	$ 19,336,748	17.92%	Note 1	Note 2	$ 6,499,804	$ 5,929,105	$ 4,301,684	$ 16,730,593	$ 29,345,814	$ 12,615,221

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
DISPROPORTIONATE SHARE HOSPITAL DATA REPORTING FORM
MEDICAID STATE PLAN RATE YEAR 2007

		1	2	3	4	5	6	7	8	9	10
Provider Number	Provider Name	State Estimated Hospital-Specific DSH Limit	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
23-1320	Lakeshore Community Hospital	$ 1,647,139	23.35%	Note 1	Note 2	$ 986,246	$ 520,666	$ 460,730	$ 1,967,642	$ 1,662,515	$ (305,127)
23-0193	Lapeer Regional Hospital	$ 2,202,789	16.39%	Note 1	Note 2	$ 4,972,966	$ 546,192	$ 1,191,761	$ 6,710,919	$ 6,407,479	$ (303,440)
23-1330	Marlette Community Hospital	$ 754,808	4.07%	Note 1	Note 2	$ 190,493	$ -	$ 132,636	$ 323,129	$ 347,754	$ 24,625
23-0054	Marquette General Hospital	$ 5,217,785	20.03%	Note 1	Note 2	$ 16,839,001	$ -	$ 3,106,142	$ 19,945,143	$ 21,328,627	$ 1,383,484
23-3026	Mary Free Bed Hospital & Rehabilitation Center	$ 772,143	14.30%	Note 1	Note 2	$ 1,988,799	$ 402,942	$ 1,142,406	$ 3,534,147	$ 4,037,788	$ 503,641
23-1314	McKenzie Memorial Hospital	$ 875,971	10.82%	Note 1	Note 2	$ 311,940	$ -	$ 275,226	$ 587,166	$ 620,290	$ 33,124
23-0141	McLaren Regional Medical Center	$ 6,401,967	11.37%	Note 1	Note 2	$ 18,997,402	$ 8,168,879	$ 3,254,380	$ 30,420,661	$ 49,748,110	$ 19,327,449
23-0093	Mecosta County Medical Center	$ 1,273,458	19.70%	Note 1	Note 2	$ 2,109,389	$ -	$ 1,029,228	$ 3,138,617	$ 3,045,084	$ (93,533)
23-0121	Memorial Healthcare	$ 3,501,726	24.47%	Note 1	Note 4	$ 9,451,530	$ 3,026,265	$ 1,229,115	$ 13,706,910	$ 28,289,648	$ 14,582,738
23-0110	Memorial Medical Center of West Michigan	$ 2,335,738	19.43%	Note 1	Note 2	$ 3,823,319	$ -	$ 1,865,970	$ 5,689,289	$ 6,745,126	$ 1,055,837
23-0004	Mercy General Health Partners	$ 11,501,303	18.51%	Note 1	Note 2	$ 20,054,659	$ 8,746,886	$ 3,011,468	$ 31,813,013	$ 40,133,145	$ 8,320,132
23-0081	Mercy Hospital - Cadillac	$ 1,721,372	15.44%	Note 1	Note 2	$ 2,125,081	$ 4,767,809	$ 1,794,885	$ 8,687,775	$ 9,424,790	$ 737,015
23-0058	Mercy Hospital - Grayling	$ 2,245,698	15.51%	Note 1	Note 2	$ 1,333,195	$ 1,662,078	$ 978,117	$ 3,973,390	$ 5,330,779	$ 1,357,389
23-0031	Mercy Hospital - Port Huron	$ 2,977,617	7.30%	Note 1	Note 2	$ 5,487,718	$ 2,421,030	$ 810,035	$ 8,718,783	$ 11,822,919	$ 3,104,136
23-0099	Mercy Memorial Hospital	$ 5,613,463	12.49%	Note 1	Note 2	$ 2,641,541	$ 1,005,075	$ 2,073,067	$ 5,719,683	$ 8,458,962	$ 2,739,279
23-0236	Metropolitan Hospital - Grand Rapids	$ 13,364,536	15.15%	Note 1	Note 2	$ 13,695,527	$ 5,686,855	$ 5,528,838	$ 24,911,220	$ 36,312,498	$ 11,401,278
23-1325	Mid Michigan Medical Center-Gladwin	$ 310,272	10.46%	Note 1	Note 2	$ 376,815	$ 593,533	$ 403,933	$ 1,374,281	$ 2,067,161	$ 692,880
23-0222	Mid Michigan Reg. Med. Ctr - Midland	$ 7,337,923	12.56%	Note 1	Note 2	$ 7,204,641	$ 2,228,260	$ 5,173,187	$ 14,606,088	$ 15,267,874	$ 661,786
23-0180	Mid-Michigan Medical Center-Clare	$ 360,467	20.02%	Note 1	Note 2	$ 2,580,428	$ 261,754	$ 2,095,695	$ 4,937,877	$ 5,412,386	$ 474,509
23-0227	Mt. Clemens General Hospital	$ 18,770,697	11.30%	Note 1	Note 2	$ 12,160,714	$ 5,704,225	$ 4,850,638	$ 22,715,577	$ 27,001,483	$ 4,285,906
23-0097	Munson Medical Center	$ 7,811,737	11.21%	Note 1	Note 2	$ 29,371,179	$ 3,944,599	$ 8,431,308	$ 41,747,086	$ 40,345,288	$ (1,401,798)
23-0013	North Oakland Medical Center	$ 9,306,766	16.85%	Note 1	Note 2	$ 8,152,422	$ 4,598,130	$ 4,759,000	$ 17,509,552	$ 18,382,516	$ 872,964
23-0174	North Ottawa Community Hospital	$ 1,480,740	8.55%	Note 1	Note 2	$ 628,081	$ 900,771	$ 370,310	$ 1,899,162	$ 2,274,063	$ 374,901
23-0105	Northern Michigan Hospitals, Inc.	$ 7,386,880	10.22%	Note 1	Note 2	$ 5,668,997	$ 752,705	$ 3,264,536	$ 9,686,238	$ 9,990,998	$ 304,760
23-0217	Oaklawn Hospital	$ 7,409,662	16.76%	Note 1	Note 2	$ 1,120,551	$ -	$ 733,198	$ 1,853,749	$ 2,527,688	$ 673,939
23-0142	Oakwood Annapolis Hospital	$ 7,783,390	18.34%	Note 1	Note 2	$ 17,259,974	$ 5,866,649	$ 2,666,653	$ 25,793,276	$ 30,336,601	$ 4,543,325
23-0270	Oakwood Heritage Hospital	$ 7,292,500	12.90%	Note 1	Note 2	$ 17,597,921	$ 3,650,533	$ 1,245,787	$ 22,494,241	$ 26,970,563	$ 4,476,322
23-0020	Oakwood Hospital and Medical Center	$ 15,118,125	17.78%	Note 1	Note 2	$ 52,938,599	$ 24,099,259	$ 12,849,351	$ 89,887,209	$ 95,474,737	$ 5,587,528
23-0176	Oakwood Southshore Medical Center	$ 1,506,411	8.29%	Note 1	Note 2	$ 6,948,729	$ 1,881,638	$ 1,148,392	$ 9,978,759	$ 13,047,662	$ 3,068,903
23-1309	Ontonagon Memorial Hospital	$ 1,709,112	2.57%	Note 1	Note 2	$ 38,393	$ -	$ 127,158	$ 165,551	$ 77,466	$ (88,085)
23-0133	Otsego County Memorial Hospital	$ 1,826,483	16.83%	Note 1	Note 2	$ 1,351,369	$ -	$ 1,061,306	$ 2,412,675	$ 2,289,224	$ (123,451)
23-0040	Pennock Hospital	$ 1,858,905	13.02%	Note 1	Note 2	$ 1,328,479	$ 866,888	$ 1,047,633	$ 3,243,000	$ 2,983,814	$ (259,186)
23-0207	POH Medical Center	$ 15,906,099	12.82%	Note 1	Note 2	$ 2,233,326	$ 6,380,871	$ 4,284,151	$ 12,898,348	$ 14,380,798	$ 1,482,450
23-0216	Port Huron Hospital	$ 6,894,477	14.84%	Note 1	Note 2	$ 8,078,793	$ 6,224,248	$ 2,539,951	$ 16,842,992	$ 21,696,439	$ 4,853,447
23-0108	Portage Health Systems	$ 1,326,588	12.06%	Note 1	Note 2	$ 751,636	$ -	$ 484,072	$ 1,235,708	$ 1,813,349	$ 577,641
23-0019	Providence Hospital	$ 12,108,641	11.89%	Note 1	Note 2	$ 35,614,550	$ 9,614,414	$ 6,352,493	$ 51,581,457	$ 55,694,585	$ 4,113,128
23-3027	Rehabilitation Institute	$ 3,188,166	23.72%	Note 1	Note 2	$ 10,372,208	$ 8,260,382	$ 2,089,824	$ 20,722,414	$ 13,664,477	$ (7,057,937)
23-1305	Saint Mary's Standish Community Hospital	$ 866,775	8.90%	Note 1	Note 2	$ 159,875	$ 871,588	$ 165,203	$ 1,196,666	$ 1,724,524	$ 527,858
23-1310	Scheurer Hospital	$ 635,918	2.58%	Note 1	Note 2	$ 117,651	$ -	$ 172,213	$ 289,864	$ 379,886	$ 90,022
23-1303	Schoolcraft Memorial Hospital	$ 925,526	3.68%	Note 1	Note 2	$ 263,377	$ 51,626	$ 83,468	$ 398,471	$ 550,026	$ 151,555
23-1312	Sheridan Community Hospital	$ 1,374,043	10.97%	Note 1	Note 2	$ 113,056	$ -	$ 443,480	$ 556,536	$ 350,890	$ (205,646)
23-0024	Sinai-Grace Hospital	$ 35,797,748	30.80%	Note 1	Note 2	$ 63,283,691	$ 34,259,555	$ 22,380,115	$ 119,923,361	$ 152,211,198	$ 32,287,837
23-0085	South Haven Community Hospital	$ 1,527,836	33.40%	Note 1	Note 2	$ 1,663,564	$ 2,029,579	$ 961,490	$ 4,654,633	$ 5,708,809	$ 1,054,176
23-0264	Southeast Michigan Surgical Hospital	$ 448,808	11.09%	Note 1	Note 2	$ 98,581	$ -	$ 96,329	$ 194,910	$ 119,994	$ (74,916)
23-0038	Spectrum Health	$ 18,153,354	20.35%	Note 1	Note 2	$ 47,465,934	$ 36,490,399	$ 36,232,451	$ 120,188,784	$ 132,646,406	$ 12,457,622
23-1323	Spectrum Health - Reed City Campus	$ 1,961,636	9.01%	Note 1	Note 2	$ 454,539	$ 1,281,264	$ 399,753	$ 2,135,556	$ 3,498,687	$ 1,363,131
23-0101	St. Francis Hospital	$ 3,995,692	20.42%	Note 1	Note 2	$ 1,015,789	$ 1,504,139	$ 782,754	$ 3,302,682	$ 5,497,572	$ 2,194,890
23-0119	St. John Detroit Riverview Hospital	$ 30,864,237	39.85%	Note 1	Note 2	$ 6,113,772	$ 12,689,351	$ 6,765,551	$ 25,568,674	$ 45,506,328	$ 19,937,654
23-0165	St. John Hospital and Medical Center	$ 30,915,538	23.12%	Note 1	Note 2	$ 27,565,041	$ 31,428,514	$ 18,750,650	$ 77,744,205	$ 96,904,301	$ 19,160,096
23-0195	St. John Macomb Hospital	$ 8,341,272	10.00%	Note 1	Note 2	$ 5,869,308	$ 5,967,103	$ 2,754,081	$ 14,590,492	$ 20,033,660	$ 5,443,168
23-0223	St. John Oakland Hospital	$ 3,088,429	12.38%	Note 1	Note 2	$ 11,709,630	$ 4,905,697	$ 2,908,127	$ 19,523,454	$ 20,149,002	$ 625,548
23-0241	St. John River District Hospital	$ 848,085	11.65%	Note 1	Note 2	$ 2,142,350	$ 1,079,697	$ 538,401	$ 3,760,448	$ 6,191,689	$ 2,431,241
23-0156	St. Joseph Mercy Hospital - Ann Arbor	$ 24,552,164	7.36%	Note 1	Note 2	$ 28,053,322	$ 5,682,820	$ 5,020,430	$ 38,756,572	$ 70,430,432	$ 31,673,860
23-0047	St. Joseph Mercy Hospital & Health Services	$ 11,681,423	14.96%	Note 1	Note 2	$ 4,650,713	$ -	$ 2,333,348	$ 6,984,061	$ 6,499,536	$ (484,525)
23-0069	St. Joseph Mercy Livingston Hospital	$ 3,465,653	11.48%	Note 1	Note 2	$ 4,408,603	$ 403,161	$ 939,451	$ 5,751,215	$ 6,927,778	$ 1,176,563
23-0029	St. Joseph Mercy Oakland	$ 14,763,686	11.65%	Note 1	Note 2	$ 11,824,590	$ 1,587,798	$ 5,560,015	$ 18,972,403	$ 18,811,586	$ (160,817)

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		1	2	3	4	5	6	7	8	9	10
Provider Number	Provider Name	State Estimated Hospital-Specific DSH Limit	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
23-0002	St. Mary Mercy Hospital	$ 941,735	4.92%	Note 1	Note 2	$ 2,879,967	$ 1,693,664	$ 950,328	$ 5,523,959	$ 8,506,506	$ 2,982,547
23-0059	St. Mary's Health Care (Grand Rapids)	$ 16,711,425	23.44%	Note 1	Note 2	$ 24,247,087	$ 6,912,819	$ 5,510,032	$ 36,669,938	$ 84,906,244	$ 48,236,306
23-0077	St. Mary's Medical Center - Saginaw	$ 7,805,165	11.45%	Note 1	Note 2	$ 18,778,310	$ 8,513,771	$ 3,743,620	$ 31,035,701	$ 39,091,872	$ 8,056,171
23-0096	Sturgis Memorial Hospital	$ 807,925	28.40%	Note 1	Note 2	$ 1,025,240	$ -	$ 1,084,565	$ 2,109,805	$ 2,086,184	$ (23,621)
23-0100	Tawas St. Joseph Hospital	$ 2,312,455	7.24%	Note 1	Note 2	$ 825,292	$ 1,308,322	$ 320,302	$ 2,453,916	$ 3,395,815	$ 941,899
23-0015	Three Rivers Area Hospital	$ 1,880,482	17.42%	Note 1	Note 2	$ 1,076,181	$ -	$ 739,854	$ 1,816,035	$ 2,220,206	$ 404,171
23-0035	United Memorial Health Center	$ 3,885,857	18.13%	Note 1	Note 2	$ 1,047,865	$ 1,489,597	$ 771,995	$ 3,309,457	$ 4,556,983	$ 1,247,526
23-0046	University of Michigan Health System	$ 20,225,434	17.99%	Note 1	Note 2	$ 118,038,809	$ 23,978,888	$ 74,118,090	$ 216,135,787	$ 237,975,950	$ 21,840,163
23-0092	W.A. Foote Memorial Hospital	$ 30,140,030	13.68%	Note 1	Note 2	$ 6,843,383	$ 9,573,434	$ 3,618,557	$ 20,035,374	$ 35,668,287	$ 15,632,913
23-0095	West Branch Regional Medical Center	$ 944,136	11.25%	Note 1	Note 2	$ 2,584,693	$ -	$ 977,725	$ 3,562,418	$ 3,759,747	$ 197,329
23-0060	West Shore Medical Center	$ 1,107,472	15.31%	Note 1	Note 2	$ 713,603	$ -	$ 1,064,229	$ 1,777,832	$ 1,562,130	$ (215,702)
23-0130	William Beaumont Hospital - Royal Oak	$ 26,115,547	6.85%	Note 1	Note 2	$ 19,744,944	$ -	$ 14,157,875	$ 33,902,819	$ 31,920,126	$ (1,982,693)
23-0269	William Beaumont Hospital - Troy	$ 4,730,116	3.85%	Note 1	Note 2	$ 4,058,146	$ 2,969,025	$ 2,187,985	$ 9,215,156	$ 14,563,265	$ 5,348,109
23-0003	Zeeland Community Hospital	$ 456,917	6.70%	Note 1	Note 2	$ 1,213,747	$ 693	$ 419,043	$ 1,633,483	$ 1,898,140	$ 264,657
Out-of-State DSH Hospitals											
None											
Institute for Mental Disease											
23-4025	Caro Center	$ 33,895,043	9.27%	Note 1	Note 2	$ 2,727,855	$ -	$ -	$ 2,727,855	$ 3,418,994	$ 691,139
23-4026	Kalamazoo Psychiatric Hospital	$ 31,196,458	7.87%	Note 1	Note 2	$ 2,719,901	$ -	$ -	$ 2,719,901	$ 3,691,578	$ 971,677
23-4035	Walter Reuther Psychiatric Hospital	$ 39,410,400	6.38%	Note 1	Note 2	$ 2,138,309	$ -	$ -	$ 2,138,309	$ 3,376,157	$ 1,237,848
23-0320	Hawthorn	$ 3,919,485	95.80%	Note 1	Note 2	$ 15,669,440	$ -	$ -	$ 15,669,440	$ 17,107,938	$ 1,438,498
	Forensic Facility	$ 52,296,015	0.00%	Note 1	Note 3	$ -	$ -	$ -	$ -	$ -	$ -
23-4011	Kingswood Psychiatric Hospital	$ 1,466,182	60.88%	Note 1	Note 2	$ -	$ 4,736,121	$ 227,632	$ 4,963,753	$ 6,395,538	$ 1,431,785
23-4023	Havenwyck Hospital	$ 866,167	29.66%	Note 1	Note 2	$ 2,077,926	$ -	$ -	$ 2,077,926	$ 1,674,061	$ (403,865)

Note 1: Michigan does not utilize a minimum threshold for LIUR to qualify for DSH payments

Note 2: Meets requirement of Medicaid Utilization rate of at least 1%

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

Note 4: Hospital did not meet the State and Federal DSH requirement of performing non-emergency obstetric services

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Provider Number	Provider Name	Uninsured IP/OP Revenue	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
23-1328	Allegan General Hospital	$ 328,496	$ -	$ 987,441	$ 658,945	$ 2,577,529	$ 684,300
23-0036	Alpena General Hospital	$ 253,265	$ -	$ 4,262,485	$ 4,009,220	$ 36,593,781	$ 4,474,363
23-0075	Battle Creek Health System	$ 365,040	$ -	$ 4,782,322	$ 4,417,282	$ 17,301,352	$ 1,449,525
23-0041	Bay Medical Center	$ 222,422	$ -	$ 1,581,722	$ 1,359,300	$ 117,015,263	$ 2,644,629
23-1321	Bell Memorial Hospital	$ 336,572	$ -	$ 907,920	$ 571,348	$ 841,798	$ 401,434
23-0204	Bi-County Community Hospital	$ 6,011,726	$ -	$ 9,629,548	$ 3,617,822	$ 7,246,871	$ 170,395
23-0089	Bon Secours Hospital	$ 251,367	$ -	$ 4,604,909	$ 4,353,542	$ 4,365,298	$ 126,057
23-0117	Borgess Hospital	$ 824,166	$ -	$ 8,434,541	$ 7,610,375	$ 9,442,036	$ 1,935,179
23-0151	Botsford General Hospital	$ 533,704	$ -	$ 5,136,994	$ 4,603,290	$ 3,615,076	$ 371,781
23-0017	Bronson Methodist Hospital	$ 1,156,623	$ -	$ 10,045,713	$ 8,889,090	$ 66,905,239	$ 8,248,112
23-0190	Bronson Vicksburg Hospital	$ 46,985	$ -	$ 259,397	$ 212,412	$ 378,269	$ 280,183
23-1329	Caro Community Hospital	$ 247,728	$ -	$ 410,624	$ 162,896	$ 99,897	$ 74,172
23-0208	Carson City Osteopathic Hospital	$ 1,857,961	$ -	$ 1,824,779	$ (33,182)	$ (72,364)	$ 2,420,916
23-0080	Central Michigan Community Hospital	$ 553,782	$ -	$ 1,275,958	$ 722,176	$ 874,534	$ 648,759
23-1322	Charlevoix Area Hospital	$ 238,396	$ -	$ 594,791	$ 356,395	$ 1,213,375	$ 754,449
23-0034	Cheboygan Memorial Hospital	$ -	$ -	$ 1,286,181	$ 1,286,181	$ 926,380	$ 172,478
23-0259	Chelsea Community Hospital	$ -	$ -	$ 337,007	$ 337,007	$ 1,637,301	$ 405,211
23-3300	Children's Hospital of Michigan	$ 20,829	$ -	$ 314,905	$ 294,076	$ 31,298,929	$ 16,448,824
23-0239	Chippewa War Memorial Hospital	$ 152,807	$ -	$ 779,394	$ 626,587	$ 969,479	$ 529,638
23-1326	Clinton Memorial Hospital	$ 896,708	$ -	$ 525,128	$ (371,580)	$ (561,435)	$ 254,507
23-0022	Community Health Center of Branch County	$ 1,597,944	$ -	$ 2,001,949	$ 404,005	$ 5,061,101	$ 3,200,883
23-0078	Community Hospital - Watervliet	$ 406,835	$ -	$ 1,078,379	$ 671,544	$ 2,642,699	$ 474,850
23-0070	Covenant Medical Center, Inc.	$ 57,020	$ -	$ 5,085,894	$ 5,028,874	$ 5,171,334	$ 1,799,154
23-0254	Crittenton Hospital	$ 2,811,493	$ -	$ 4,130,641	$ 1,319,148	$ 10,531,194	$ 284,486
23-0273	Detroit Receiving Hospital	$ 5,170,762	$ -	$ 34,333,779	$ 29,163,017	$ 45,649,422	$ 7,976,038
23-0055	Dickinson County Memorial Hospital	$ 94,838	$ -	$ 520,206	$ 425,368	$ 1,098,557	$ 2,327,893
23-0230	Edward W. Sparrow Hospital	$ 1,870,730	$ -	$ 14,108,686	$ 12,237,956	$ 7,054,667	$ 5,926,807
23-0005	Emma L. Bixby Medical Center	$ 207,135	$ -	$ 1,381,131	$ 1,173,996	$ 2,779,535	$ 726,528
23-0244	Garden City Osteopathic Hospital	$ 163,819	$ -	$ 4,262,522	$ 4,098,703	$ 4,116,583	$ 443,980
23-0197	Genesys Regional Medical Center	$ 138,924	$ -	$ 646,582	$ 507,658	$ 6,933,905	$ 9,431,883
23-0106	Gerber Memorial Hospital	$ 16,801	$ -	$ 60,360	$ 43,559	$ 1,375,261	$ 1,623,421
23-1333	Grand View Hospital	$ -	$ -	$ 686,052	$ 686,052	$ 927,448	$ 322,624
23-0030	Gratiot Community Hospital	$ 402,851	$ -	$ 642,639	$ 239,788	$ 211,148	$ 13,714
23-0066	Hackley Hospital	$ 4,831,669	$ -	$ 9,930,648	$ 5,098,979	$ 8,217,707	$ 1,982,247
23-0104	Harper University Hospital	$ 558,428	$ -	$ 6,074,209	$ 5,515,781	$ 61,800,500	$ 57,688,655
23-1327	Hayes Green Beach Memorial Hospital	$ 418,368	$ -	$ 1,430,590	$ 1,012,222	$ 1,166,443	$ 1,116,094
23-0275	Healthsource Saginaw	$ 52,400	$ -	$ 126,828	$ 74,428	$ 98,582	$ 168,858
23-1304	Helen Newberry Joy Hospital	$ 108,944	$ -	$ 678,599	$ 569,655	$ 851,404	$ 1,351,802
23-0053	Henry Ford Hospital	$ 11,762,967	$ 51,209	$ 36,605,692	$ 24,791,516	$ 10,108,812	$ 3,598,822
23-0146	Henry Ford Wyandotte Hospital	$ 4,110,443	$ -	$ 6,234,085	$ 2,123,642	$ 3,382,524	$ 480,352
23-1334	Herrick Memorial Hospital, Inc.	$ 1,670,142	$ -	$ 1,169,655	$ (500,487)	$ (336,895)	$ 510,023
23-1316	Hills & Dales General Hospital	$ 112,158	$ -	$ 461,742	$ 349,584	$ 1,251,343	$ 54,887
23-0037	Hillsdale Community Health Center	$ 388,625	$ -	$ 1,723,278	$ 1,334,653	$ 10,453,575	$ 1,640,930
23-0072	Holland Community Hospital	$ 590,560	$ 105,904	$ 3,440,632	$ 2,744,168	$ 15,506,161	$ 360,408
23-0132	Hurley Medical Center	$ 254,815	$ -	$ 11,273,502	$ 11,018,687	$ 17,650,291	$ 25,688,651
23-0118	Huron Memorial Hospital	$ 304,112	$ -	$ 876,255	$ 572,143	$ 758,849	$ 131,160
23-0277	Huron Valley - Sinai Hospital	$ 5,963,727	$ -	$ 1,599,274	$ (4,364,453)	$ 495,793	$ 73,368
23-0167	Ingham Regional Medical Center	$ 288,700	$ -	$ 4,557,671	$ 4,268,971	$ 18,180,999	$ 5,998,013
23-1331	Ionia County Memorial Hospital	$ 458,402	$ -	$ 793,373	$ 334,971	$ (7,590)	$ 428,214
23-1301	Kalkaska Memorial Health Center	$ 72,634	$ -	$ 348,551	$ 275,917	$ 697,462	$ 811,105
23-1319	Keweenaw Memorial Medical Center	$ -	$ -	$ 308,452	$ 308,452	$ 1,169,628	$ 56,229
23-1332	Lake View Community Hospital	$ 123,257	$ -	$ 1,075,050	$ 951,793	$ 835,333	$ 758,133
23-0021	Lakeland Hospital - St. Joseph	$ 214,088	$ -	$ 2,944,810	$ 2,730,722	$ 15,345,943	$ 2,245,642

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		11	12	13	14	15	16
Provider Number	Provider Name	Uninsured IP/OP Revenue	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
23-1320	Lakeshore Community Hospital	$ 175,889	$ -	$ 699,881	$ 523,992	$ 218,865	$ 183,193
23-0193	Lapeer Regional Hospital	$ 548,495	$ -	$ 2,034,062	$ 1,485,567	$ 1,182,127	$ 245,398
23-1330	Marlette Community Hospital	$ 312,980	$ -	$ 10,603,186	$ 10,290,206	$ 10,314,831	$ 248,603
23-0054	Marquette General Hospital	$ 563,024	$ -	$ 3,940,254	$ 3,377,230	$ 4,760,714	$ 1,600,913
23-3026	Mary Free Bed Hospital & Rehabilitation Center	$ 75,212	$ -	$ 229,522	$ 154,310	$ 657,951	$ 41,274
23-1314	McKenzie Memorial Hospital	$ 666,044	$ -	$ 571,995	$ (94,049)	$ (60,925)	$ 166,692
23-0141	McLaren Regional Medical Center	$ 308,999	$ -	$ 6,269,097	$ 5,960,098	$ 25,287,547	$ 6,401,557
23-0093	Mecosta County Medical Center	$ 362,101	$ -	$ 1,261,050	$ 898,949	$ 805,416	$ 2,019,460
23-0121	Memorial Healthcare	$ 3,795,420	$ -	$ 1,795,765	$ (1,999,655)	$ 12,583,083	$ 405,850
23-0110	Memorial Medical Center of West Michigan	$ 8,941	$ -	$ 1,029,697	$ 1,020,756	$ 2,076,593	$ 1,670,096
23-0004	Mercy General Health Partners	$ 431,688	$ -	$ 3,986,041	$ 3,554,353	$ 11,874,485	$ 1,669,969
23-0081	Mercy Hospital - Cadillac	$ 1,167,550	$ -	$ 1,406,443	$ 238,893	$ 975,908	$ 328,755
23-0058	Mercy Hospital - Grayling	$ 656,163	$ -	$ 1,063,098	$ 406,935	$ 1,764,324	$ 1,227,838
23-0031	Mercy Hospital - Port Huron	$ 304,448	$ -	$ 1,556,282	$ 1,251,834	$ 4,355,970	$ 122,192
23-0099	Mercy Memorial Hospital	$ 86,047	$ -	$ 3,322,454	$ 3,236,407	$ 5,975,686	$ 1,345,568
23-0236	Metropolitan Hospital - Grand Rapids	$ 565,960	$ -	$ 2,882,475	$ 2,316,515	$ 13,717,793	$ 1,423,260
23-1325	Mid Michigan Medical Center-Gladwin	$ 595,403	$ -	$ 721,635	$ 126,232	$ 819,112	$ 310,272
23-0222	Mid Michigan Reg. Med. Ctr - Midland	$ 430,903	$ -	$ 4,038,902	$ 3,607,999	$ 4,269,785	$ 3,332,267
23-0180	Mid-Michigan Medical Center-Clare	$ 2,677,016	$ -	$ 2,016,104	$ (660,912)	$ (186,403)	$ 360,467
23-0227	Mt. Clemens General Hospital	$ 557,445	$ -	$ 4,492,999	$ 3,935,554	$ 8,221,460	$ 5,645,099
23-0097	Munson Medical Center	$ 437,765	$ -	$ 5,992,409	$ 5,554,644	$ 4,152,846	$ 3,683,326
23-0013	North Oakland Medical Center	$ 2,028,667	$ -	$ 3,199,297	$ 1,170,630	$ 2,043,594	$ 391,303
23-0174	North Ottawa Community Hospital	$ 110,517	$ -	$ 1,079,753	$ 969,236	$ 1,344,137	$ 650,666
23-0105	Northern Michigan Hospitals, Inc.	$ 73,129	$ -	$ 3,183,807	$ 3,110,678	$ 3,415,438	$ 2,093,217
23-0217	Oaklawn Hospital	$ 164,022	$ -	$ 1,807,978	$ 1,643,956	$ 2,317,895	$ 199,118
23-0142	Oakwood Annapolis Hospital	$ 84,452	$ -	$ 7,478,354	$ 7,393,902	$ 11,937,227	$ 141,532
23-0270	Oakwood Heritage Hospital	$ 245,516	$ -	$ 4,307,003	$ 4,061,487	$ 8,537,809	$ 244,483
23-0020	Oakwood Hospital and Medical Center	$ 2,123,281	$ -	$ 12,712,938	$ 10,589,657	$ 16,177,185	$ 8,761,281
23-0176	Oakwood Southshore Medical Center	$ 75,105	$ -	$ 6,333,707	$ 6,258,602	$ 9,327,505	$ 26,148
23-1309	Ontonagon Memorial Hospital	$ 198,328	$ -	$ 497,186	$ 298,858	$ 210,773	$ 1,709,086
23-0133	Otsego County Memorial Hospital	$ 464,165	$ -	$ 1,570,231	$ 1,106,066	$ 982,615	$ 939,805
23-0040	Pennock Hospital	$ 288,046	$ -	$ 1,680,856	$ 1,392,810	$ 1,133,624	$ 1,003,256
23-0207	POH Medical Center	$ 798,437	$ -	$ 6,567,463	$ 5,769,026	$ 7,251,476	$ 832,557
23-0216	Port Huron Hospital	$ 480,584	$ -	$ 2,229,821	$ 1,749,237	$ 6,602,684	$ 235,104
23-0108	Portage Health Systems	$ -	$ -	$ 1,044,213	$ 1,044,213	$ 1,621,854	$ 777,576
23-0019	Providence Hospital	$ 7,413,968	$ -	$ 7,911,325	$ 497,357	$ 4,610,485	$ 460,150
23-3027	Rehabilitation Institute	$ 468,326	$ -	$ 30,590,265	$ 30,121,939	$ 23,064,002	$ 379,771
23-1305	Saint Mary's Standish Community Hospital	$ 105,112	$ -	$ 512,838	$ 407,726	$ 935,584	$ 157,588
23-1310	Scheurer Hospital	$ 31,462	$ -	$ 532,965	$ 501,503	$ 591,525	$ 68,327
23-1303	Schoolcraft Memorial Hospital	$ 283,313	$ -	$ 706,824	$ 423,511	$ 575,066	$ 1,422,812
23-1312	Sheridan Community Hospital	$ 56,489	$ -	$ 367,934	$ 311,445	$ 105,799	$ 165,200
23-0024	Sinai-Grace Hospital	$ 1,990,926	$ -	$ 17,931,255	$ 15,940,329	$ 48,228,166	$ 4,381,865
23-0085	South Haven Community Hospital	$ 372,799	$ -	$ 1,738,329	$ 1,365,530	$ 2,419,706	$ 1,676,621
23-0264	Southeast Michigan Surgical Hospital	$ -	$ -	$ -	$ -	$ (74,916)	$ 13,232
23-0038	Spectrum Health	$ 556,409	$ -	$ 16,635,802	$ 16,079,393	$ 28,537,015	$ 3,115,445
23-1323	Spectrum Health - Reed City Campus	$ 1,192,633	$ -	$ 1,569,700	$ 377,067	$ 1,740,198	$ 1,194,921
23-0101	St. Francis Hospital	$ 2,346,179	$ -	$ 1,530,804	$ (815,375)	$ 1,379,515	$ 666,457
23-0119	St. John Detroit Riverview Hospital	$ 5,688,550	$ -	$ 7,898,212	$ 2,209,662	$ 22,147,316	$ 387,387
23-0165	St. John Hospital and Medical Center	$ 2,439,877	$ -	$ 17,235,522	$ 14,795,645	$ 33,955,741	$ 6,241,365
23-0195	St. John Macomb Hospital	$ 825,525	$ -	$ 5,167,276	$ 4,341,751	$ 9,784,919	$ 2,420,445
23-0223	St. John Oakland Hospital	$ 2,425,539	$ -	$ 4,134,329	$ 1,708,790	$ 2,334,338	$ 234,515
23-0241	St. John River District Hospital	$ 1,604,922	$ -	$ 1,615,953	$ 11,031	$ 2,442,272	$ 295,403
23-0156	St. Joseph Mercy Hospital - Ann Arbor	$ 1,568,229	$ -	$ 14,985,938	$ 13,417,709	$ 45,091,569	$ 8,437,865
23-0047	St. Joseph Mercy Hospital & Health Services	$ 677,233	$ -	$ 3,308,594	$ 2,631,361	$ 2,146,836	$ 244,799
23-0069	St. Joseph Mercy Livingston Hospital	$ 326,551	$ -	$ 2,174,328	$ 1,847,777	$ 3,024,340	$ 1,886,443
23-0029	St. Joseph Mercy Oakland	$ 2,360,056	$ -	$ 9,056,118	$ 6,696,062	$ 6,535,245	$ 603,689

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
DISPROPORTIONATE SHARE HOSPITAL DATA REPORTING FORM
MEDICAID STATE PLAN RATE YEAR 2007

		11	12	13	14	15	16
Provider Number	Provider Name	Uninsured IP/OP Revenue	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
23-0002	St. Mary Mercy Hospital	$ 168,274	$ -	$ 2,465,862	$ 2,297,588	$ 5,280,135	$ 91,241
23-0059	St. Mary's Health Care (Grand Rapids)	$ 466,413	$ -	$ 7,521,645	$ 7,055,232	$ 55,291,538	$ 2,180,282
23-0077	St. Mary's Medical Center - Saginaw	$ 572,573	$ -	$ 224,659	$ (347,914)	$ 7,708,257	$ 402,125
23-0096	Sturgis Memorial Hospital	$ 25,933,901	$ -	$ 28,688,258	$ 2,754,357	$ 2,730,736	$ 2,580,761
23-0100	Tawas St. Joseph Hospital	$ 450,781	$ -	$ 927,068	$ 476,287	$ 1,418,186	$ 897,390
23-0015	Three Rivers Area Hospital	$ 423,865	$ -	$ 1,783,217	$ 1,359,352	$ 1,763,523	$ 1,880,482
23-0035	United Memorial Health Center	$ 527,199	$ -	$ 1,062,973	$ 535,774	$ 1,783,300	$ 588,914
23-0046	University of Michigan Health System	$ 1,797,756	$ -	$ 21,379,264	$ 19,581,508	$ 41,421,671	$ 20,225,434
23-0092	W.A. Foote Memorial Hospital	$ 10,495	$ -	$ 4,458,455	$ 4,447,960	$ 20,080,873	$ 2,287,253
23-0095	West Branch Regional Medical Center	$ 174,256	$ -	$ 1,094,199	$ 919,943	$ 1,117,272	$ 1,720,007
23-0060	West Shore Medical Center	$ -	$ -	$ 1,127,893	$ 1,127,893	$ 912,191	$ 3,209,504
23-0130	William Beaumont Hospital - Royal Oak	$ 622,117	$ -	$ 4,108,214	$ 3,486,097	$ 1,503,404	$ 1,963,867
23-0269	William Beaumont Hospital - Troy	$ 1,057,070	$ -	$ 9,026,008	$ 7,968,938	$ 13,317,047	$ 155,194
23-0003	Zeeland Community Hospital	$ 1,286,275	$ -	$ 910,730	$ (375,545)	$ (110,888)	$ 136,338
Out-of-State DSH Hospitals							
None							
Institute for Mental Disease							
23-4025	Caro Center	$ 2,388	$ -	$ 22,852,232	$ 22,849,844	$ 23,540,983	$ 33,895,043
23-4026	Kalamazoo Psychiatric Hospital	$ 30,216	$ -	$ 21,849,084	$ 21,818,868	$ 22,790,545	$ 31,196,458
23-4035	Walter Reuther Psychiatric Hospital	$ 196,619	$ -	$ 21,728,764	$ 21,532,145	$ 22,769,993	$ 39,410,400
23-0320	Hawthorn	$ -	$ -	$ 311,451	$ 311,451	$ 1,749,949	$ 3,919,485
	Forensic Facility	$ -	$ -	$ -	$ -	$ -	$ 33,487,914
23-4011	Kingswood Psychiatric Hospital	$ -	$ -	$ 301,759	$ 301,759	$ 1,733,544	$ 595,908
23-4023	Havenwyck Hospital	$ -	$ -	$ 1,532,629	$ 1,532,629	$ 1,128,764	$ 817,039

Note 1: Michigan does not utilize a minimum threshold for LIUR to qualify for DSH payments

Note 2: Meets requirement of Medicaid Utilization rate of at least 1%

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

Note 4: Hospital did not meet the State and Federal DSH requirement of performing non-emergency obstetric services

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
SUMMARY OF FINDINGS

Finding 1 –

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 28 hospitals in Michigan received DSH payments in MSP rate year 2007 that exceeded the hospital-specific DSH limit. Except for the one hospital that did not provide adequate documentation to calculate the hospital-specific DSH limit, we found 27 hospitals received DSH payments exceeding their hospital-specific DSH payment limits calculated based on the DSH Rule.

Recommendation
We recommend that MDCH utilize the findings noted during this and subsequent agreed-upon procedures 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 2 –

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 27 hospitals for MSP rate year 2007 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 3 –

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 2007 State MSP is silent as to the payments to be offset against uncompensated costs 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 4 –

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

Two of the 130 hospitals that received DSH payments in MSP rate year 2007 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. In addition, two of the 130 hospitals that received DSH payments in MSP rate year 2007 did not meet the minimum 1% Medicaid Inpatient Utilization Rate required to qualify for DSH.

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.

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 two (2) hospitals in MSP rate year 2007 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 two hospitals 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).

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 two hospitals 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 originally calculated hospital-specific DSH payment limit computed based on the Centers for Medicare and Medicaid Services (CMS) approved MSP effective in MSP rate year 2007. 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 2007 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, 28 hospitals in MSP rate year 2007 received DSH payments that exceeded their hospital-specific DSH payment limits, calculated based on the final 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 2007 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 2007 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 45 hospitals and found that 27 of these 45 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 2007 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, 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. 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.