STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
Lansing, Michigan

DISPROPORTIONATE SHARE PROGRAM
AGREED UPON PROCEDURES
Medicaid State Plan Rate Year September 30, 2008

Clifton Gunderson LLP
Certified Public Accountants & Consultants

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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 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, 2007 through September 30, 2008. 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.

The results noted from conducting the procedures are presented in the Summary of Results included in 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
September 30, 2011

Schedule of Disproportionate Share
Hospital Low Procedures

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. f. Ensure GME costs are reflected in cost-to-charge ratios through investigation of Worksheet E -3, Part IV.
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 of Disproportionate Share
Hospital Low Procedures

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 #1.
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 of Disproportionate Share
Hospital Low Procedures

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 of Disproportionate Share
Hospital Low Procedures

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 of Disproportionate Share
Hospital Low Procedures

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 of Disproportionate Share
Hospital Low Procedures

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 of Disproportionate Share
Hospital Low Procedures

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 of Disproportionate Share
Hospital Low Procedures

Review of Uninsured Charges

STEP NO.	PROCEDURES
9.	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.
10.	Review each reject 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).
11.	If professional fees are identified during the review of sample, request listing of professional fees for all accounts reported on Clean Listings.
12.	Review documentation concerning sample errors and determine any modification of results as needed.
13.	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.
14.	Determine error rate of sample reviews and extrapolate error rate to Clean Listing population.

Schedule of Disproportionate Share
Hospital Low Procedures

Review of Non-Governmental and Non-Third Payer Payments

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

Schedule of Disproportionate Share
Hospital Low Procedures

Review of Non-Governmental and Non-Third Payer Payments

STEP NO.	PROCEDURES
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) 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 of Disproportionate Share
Hospital Low Procedures

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 of Disproportionate Share
Hospital Low Procedures

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 of Disproportionate Share
Hospital Low Procedures

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 of Disproportionate Share
Hospital Low Procedures

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.
5.	Send each hospital the verified PDSS information for review prior to issuing a draft report to the State.

Schedule of Disproportionate Share
Hospital Minimal Procedures

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. f. Ensure GME costs are reflected in cost-to-charges ratios through investigation of Worksheet E-3, Part IV.
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 of Disproportionate Share
Hospital Minimal Procedures

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 #1.
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 of Disproportionate Share
Hospital Minimal Procedures

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.
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 of Disproportionate Share
Hospital Minimal Procedures

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 payment 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 of Disproportionate Share
Hospital Minimal Procedures

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 of Disproportionate Share
Hospital Minimal Procedures

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 of Disproportionate Share
Hospital Minimal Procedures

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).
3.	Review detailed self pay payment listing obtained from the provider to determine that payments that should be treated as Uninsured IP/OP Revenue. If the provider did not furnish a detailed self payment listing, then treat all self pay payments provider received during the MSP rate year as Uninsured IP/OP Revenue.
4.	Summarize Federal Applicable Section 1011 Payments and Uninsured IP/OP Revenue and adjust the Provider Data Summary Schedule.

Schedule of Disproportionate Share
Hospital Minimal Procedures

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 of Disproportionate Share
Hospital Minimal Procedures

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.
8.	Verify that DSH funds received by the providers reconcile with the amount reported as paid by the state.

Schedule of Disproportionate Share
Hospital Minimal Procedures

Miscellaneous Hospital Reporting Provisions

STEP NO.	PROCEDURES
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 of Disproportionate Share
Hospital Minimal Procedures

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.
5.	Send each hospital the verified PDSS information for review prior to issuing a draft report to the State.

Schedule of Disproportionate Share
State Level Procedures

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 of Disproportionate Share
State Level Procedures

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 of Disproportionate Share
State Level Procedures

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 of Disproportionate Share
State Level Procedures

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 of Disproportionate Share
State Level Procedures

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 of Disproportionate Share
State Level Procedures

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.	Determine if the State Fiscal Year is the same as the Federal Fiscal Year. a. If State Fiscal Year is the same as the Federal Fiscal Year. • Reconcile the 09/30/20xx CMS 64 Form 64.9D, Line 8, Col. E to Col. 16 of the PDSS. • Inquire of any variances greater than 1% with the State Agency. b. If State Fiscal Year is different from the Federal Fiscal Year. • Add all four quarters of the CMS 64 Forms 64.9Base, 64.9 Waiver, and 64.9 P, Lines 1B and 2B, Col. A and then reconcile to Col. 16 of the PDSS. • Inquire of any variances greater than 1% with the State Agency.
5.	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 of Disproportionate Share
State Level Procedures

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.

Schedule of Summary of Results

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
DISPROPORTIONATE SHARE PROGRAM VERIFICATIONS

The agreed upon procedures enumerated in pages 1 to 33**,** 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 results relating to each Verification are shown below.

Verification 1

We completed all the procedures described in the Schedule of Disproportionate Share Hospital Low Procedures (pages 1 to 15), the Schedule of Disproportionate Share Minimal Procedures (pages 16 to 26), and the Schedule of Disproportionate Share State Level Procedures (pages 27 to 33) relating to Verification 1 as described in 42 CFR §455.304 (d)(1) without exception except as described below.

Our procedures disclosed that two (2) hospitals in MSP rate year 2008 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.

Except for the effects discussed in the preceding paragraph, 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

We completed all the procedures described in the Schedule of Disproportionate Share Hospital Low Procedures (pages 1 to 15), the Schedule of Disproportionate Share Minimal Procedures (pages 16 to 26), and the Schedule of Disproportionate Share State Level Procedures (pages 27 to 33) relating to Verification 2 as described in 42 CFR §455.304 (d)(2) without exception except as described below.

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 2008. 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 2008 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, 40 hospitals in MSP rate year 2008 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

We completed all the procedures described in the Schedule of Disproportionate Share Hospital Low Procedures (pages 1 to 15), the Schedule of Disproportionate Share Minimal Procedures (pages 16 to 26), and the Schedule of Disproportionate Share State Level Procedures (pages 27 to 33) relating to Verification 3 as described in 42 CFR §455.304 (d)(3) without exception except as described below.

The results from completing the agreed upon procedures disclosed that the 2008 Michigan MSP, which was approved by CMS, allowed the inclusion of uncompensated costs for providing inpatient and outpatient 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. The 2008 Michigan MSP, as approved, was not in compliance with the final DSH Rule as effective on January 19, 2009. In completing the agreed upon procedures, we tested the uninsured data provided by 47 hospitals and found that 42 of these 47 hospitals included patients with insurance or third-party coverage in their self-reported uninsured data. We also noted that 3 hospitals were unable to provide an uninsured listing.

Except for the effects discussed in the preceding paragraphs, 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 were included 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.

Schedule of Summary of Results

Verification 4

We completed all the procedures described in the Schedule of Disproportionate Share Hospital Low Procedures (pages 1 to 15), the Schedule of Disproportionate Share Minimal Procedures (pages 16 to 26), and the Schedule of Disproportionate Share State Level Procedures (pages 27 to 33) relating to Verification 4 as described in 42 CFR §455.304 (d)(4) without exception except as explained below.

The results from completing the agreed upon procedures disclosed that the CMS-approved 2008 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.

Except for the effects discussed in the preceding paragraphs, 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

We completed all the procedures described in the Schedule of Disproportionate Share Hospital Low Procedures (pages 1 to 15), the Schedule of Disproportionate Share Minimal Procedures (pages 16 to 26), and the Schedule of Disproportionate Share State Level Procedures (pages 27 to 33) relating to Verification 5 as described in 42 CFR §455.304 (d)(5) without exception except as explained below.

The results from completing the agreed upon 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

We completed all the procedures described in the Schedule of Disproportionate Share Hospital Low Procedures (pages 1 to 15), the Schedule of Disproportionate Share Minimal Procedures (pages 16 to 26), and the Schedule of Disproportionate Share State Level

Schedule of Summary of Results

Procedures (pages 27 to 33) relating to Verification 6 as described in 42 CFR §455.304 (d)(6) without exception except as explained below.

The results from completing the agreed upon 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.

Exhibit I

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

The agreed upon procedures enumerated in this report**,** 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 results from conducting these procedures are described in the Summary of Results included in the report**.**

Exhibit II

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.

Exhibit II

According to Michigan's State Plan, DSH payments to qualifying hospitals are calculated as follows:
Hospitals are grouped into seven 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, state owned psychiatric hospitals and government provider pool. Hospitals may qualify for multiple pools.

The seven 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 2004.

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

The outpatient uncompensated care pool requires hospitals to meet the minimum requirements for Medicaid DSH payments. The distribution of funding from the pool is based on each hospital's proportion of outpatient uncompensated care relative to other hospitals in the pool.

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 government provider pool makes payments to public facilities providing inpatient hospital services which serve a disproportionate number of low-income patient with special needs.

Exhibit II

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 2008, 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.