Form No. DTMB-3524 (Created 4/2012)
AUTHORITY: Act 431 of 1984
COMPLETION: Required
PENALTY: No further payment will be made to the previous Contractor name and or number.

STATE OF MICHIGAN
DEPARTMENT OF TECHNOLOGY, MANAGEMENT AND BUDGET
PROCUREMENT
P.O. BOX 30026, LANSING, MI 48909
OR
530 W. ALLEGAN, LANSING, MI 48913

CHANGE OF CONTRACTOR NAME AND OR TAX IDENTIFICATION NUMBER

CONTRACT NO. 071B2200238

hereafter referred as

CONTRACT NO. 071B3200080

between

THE STATE OF MICHIGAN

and

CURRENT NAME & ADDRESS OF CONTRACTOR:	PRIMARY CONTACT	EMAIL
Myers and Stauffer LC **400 Redland Court** **Owing Mills, MD 21117**	**Frank Vito**	**Fvito@mslc.com**
	TELEPHONE	NEW CONTRACTOR #, MAIL CODE
	512-340-7425	

PREVIOUS NAME & ADDRESS OF CONTRACTOR:	PRIMARY CONTACT	EMAIL
PHBV Partners LLP **301 SW Adams Street, Ste. 600** **Peoria, IL 61656**	**Frank Vito**	**Frank.vito@phbvpartners.com**
	TELEPHONE	PREVIOUS CONTRACTOR #, MAIL CODE
	(512) 340-7425	

DESCRIPTION OF CHANGE NOTICE:
THE CONTRACTOR HAS NOTIFIED THE STATE OF MICHIGAN OF A CHANGE IN ITS BUSINESS NAME AND OR TAX IDENTIFICATION NUMBER. DUE TO THE INTERNAL SYSTEMS RELATED TO THE RELEASE OF CONTRACTOR PAYMENTS, A NEW CONTRACT NUMBER MUST BE ASSIGNED. THE NEW CONTRACT NUMBER IS 071B3200080. EXCEPT FOR THE NEWLY-ASSIGNED NUMBER, THE CONTRACT TERMS AND CONDITIONS REMAIN IN EFFECT. **THIS CHANGE IS EFFECTIVE: February 26, 2013**
$599,297.19 REMAINING ON CONTRACT # 071B2200238. TO BE TRANSFERRED TO CONTRACT # 071B3200080

Form No. DTMB-3524 (Created 4/2012)
Change of Contractor Name or Tax Identification Number

Contract No. 071B2200238 **hereafter referred as Contract No.** 071B3200080

STATE CONTACTS	AGENCY	NAME	PHONE	EMAIL
CONTRACT COMPLIANCE INSPECTOR:	**DCH**	**Greg Rivet**	**517-335-5096**	**Rivetg@michigan.gov**
BUYER:	**DTMB**	**Don Mandernach**	**517-241-7233**	**mandernachd@michigan.gov**

CONTRACT SUMMARY:			
DESCRIPTION:			
Annual Reports & Audits for Disproportionate Share Hospital Medicaid Program - DCH			
INITIAL TERM	EFFECTIVE DATE	INITIAL EXPIRATION DATE	AVAILABLE OPTIONS
5 Years	**September 1, 2009**	**September 30, 2014**	**2, 1 Year Options**
PAYMENT TERMS	F.O.B	SHIPPED	SHIPPED FROM
N/A	**N/A**	**N/A**	**N/A**
ALTERNATE PAYMENT OPTIONS:			AVAILABLE TO MiDEAL PARTICIPANTS
☐ P-card ☐ Direct Voucher (DV) ☐ Other			☐ YES ☒ NO
MINIMUM DELIVERY REQUIREMENTS:			
N/A			

FOR THE CONTRACTOR:

Myers and Stauffer LC
Firm Name

Authorized Agent Signature

Authorized Agent (Print or Type)

Date

FOR THE STATE:

Signature

Jeff Brownlee, Chief Procurement Officer
Name/Title

Enter Name of Agency

Date

Form No. DTMB-3521 (Rev. 4/2012)
AUTHORITY: Act 431 of 1984
COMPLETION: Required
PENALTY: Contract change will not be executed unless form is filed

STATE OF MICHIGAN
DEPARTMENT OF TECHNOLOGY, MANAGEMENT AND BUDGET
PROCUREMENT
P.O. BOX 30026, LANSING, MI 48909
OR
530 W. ALLEGAN, LANSING, MI 48933

August 8, 2012

CHANGE NOTICE NO. 1
to
CONTRACT NO. 071B2200238
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF CONTRACTOR:	PRIMARY CONTACT	EMAIL
PHBV Partners LLP	**Frank Vito**	**Frank.vito@phbvpartners.com**
301 SW Adams Street, Ste. 600	TELEPHONE	CONTRACTOR #, MAIL CODE
Peoria, IL 61656	**(512) 340-7425**	

STATE CONTACTS	AGENCY	NAME	PHONE	EMAIL
CONTRACT COMPLIANCE INSPECTOR:	**DCH**	**Greg Rivet**	**(517) 335-5096**	**Rivetg@michigan.gov**
BUYER:	**DTMB**	**Jim Wilson**	**(517) 241-1916**	**Wilsonj4@michigan.gov**

CONTRACT SUMMARY:

DESCRIPTION: **Annual Reports & Audits for Disproportionate Share Hospital Medicaid Program - DCH**

INITIAL EFFECTIVE DATE	INITIAL EXPIRATION DATE	AVAILABLE OPTIONS	CURRENT EXPIRATION DATE
September 1, 2009	September 30, 2014	2, 1 Yr. Options	September 30, 2014
PAYMENT TERMS	F.O.B	SHIPPED	SHIPPED FROM
N/A	**N/A**	**N/A**	**N/A**

ALTERNATE PAYMENT OPTIONS:	AVAILABLE TO MiDEAL PARTICIPANTS
☐ P-card ☐ Direct Voucher (DV) ☐ Other	☐ YES ☒ NO

MINIMUM DELIVERY REQUIREMENTS:

N/A

DESCRIPTION OF CHANGE NOTICE:

OPTION EXERCISED:	IF YES, EFFECTIVE DATE OF CHANGE:	NEW EXPIRATION DATE:
☒ NO ☐ YES		

Effective August 8, 2012, this Contract is being INCREASED by $142,930.05 to correct the amount transferred during the merger.

All other terms, conditions, specifications, and pricing remain the same.

Per DTMB approval.

VALUE/COST OF CHANGE NOTICE:	**$142,930.05**
ESTIMATED REVISED AGGREGATE CONTRACT VALUE:	**$736,622.15**

Form No. DTMB-3524 (Created 4/2012)
AUTHORITY: Act 431 of 1984
COMPLETION: Required
PENALTY: No further payment will be made to the previous Contractor name and or number.

STATE OF MICHIGAN
DEPARTMENT OF TECHNOLOGY, MANAGEMENT AND BUDGET
PROCUREMENT
P.O. BOX 30026, LANSING, MI 48909
OR
530 W. ALLEGAN, LANSING, MI 48913

June 1, 2012

CHANGE OF CONTRACTOR NAME AND OR TAX IDENTIFICATION NUMBER

CONTRACT NO. 071B9200301

hereafter referred as

CONTRACT NO. 071B2200238

between

THE STATE OF MICHIGAN

and

CURRENT NAME & ADDRESS OF CONTRACTOR:	PRIMARY CONTACT	EMAIL
PHBV Partners LLP 301 SW Adams Street, Ste. 600 Peoria, IL 61656	Frank Vito	
	TELEPHONE	NEW CONTRACTOR #, MAIL CODE
	(512) 340-7425	

PREVIOUS NAME & ADDRESS OF CONTRACTOR:	PRIMARY CONTACT	EMAIL
Clifton Gunderson LLP 120 N. Washington Square, Suite 805 Lansing, MI 48933	Deborah Freeland	Deb.Freeland@cliftoncpa.com
	TELEPHONE	PREVIOUS CONTRACTOR #, MAIL CODE
	(517) 853-2574	

DESCRIPTION OF CHANGE NOTICE:
THE CONTRACTOR HAS NOTIFIED THE STATE OF MICHIGAN OF A CHANGE IN ITS BUSINESS NAME AND OR TAX IDENTIFICATION NUMBER. DUE TO THE INTERNAL SYSTEMS RELATED TO THE RELEASE OF CONTRACTOR PAYMENTS, A NEW CONTRACT NUMBER MUST BE ASSIGNED. THE NEW CONTRACT NUMBER IS 071B2200238. EXCEPT FOR THE NEWLY-ASSIGNED NUMBER, THE CONTRACT TERMS AND CONDITIONS REMAIN IN EFFECT. **THIS CHANGE IS EFFECTIVE: June 1, 2012**
$593,692.10 REMAINING ON CONTRACT # 071B9200301 TO BE TRANSFERRED TO CONTRACT # 071B2200238

STATE CONTACTS	AGENCY	NAME	PHONE	EMAIL
CONTRACT COMPLIANCE INSPECTOR:	DCH	**Greg Rivet**	(517) 335-5096	rivetg@michigan.gov
BUYER:	DTMB	Jim Wilson	(517) 241-1916	Wilsonj4@michigan.gov

CONTRACT SUMMARY:			
DESCRIPTION: **Annual Reports & Audits for Disproportionate Share Hospital Medicaid Program - DCH**			
INITIAL TERM	EFFECTIVE DATE	INITIAL EXPIRATION DATE	AVAILABLE OPTIONS
	September 1, 2009	September 30, 2014	
PAYMENT TERMS	F.O.B	SHIPPED	SHIPPED FROM
N/A	N/A	N/A	N/A
ALTERNATE PAYMENT OPTIONS:			AVAILABLE TO MiDEAL PARTICIPANTS
☐ P-card ☐ Direct Voucher (DV) ☐ Other			☐ YES ☒ NO
MINIMUM DELIVERY REQUIREMENTS:			
N/A			

FOR THE CONTRACTOR:	**FOR THE STATE:**
PHBV Partners LLP	
Firm Name	Signature
	Jeff Brownlee, Chief Procurement Officer
Authorized Agent Signature	Name/Title
	DTMB Procurement
Authorized Agent (Print or Type)	Enter Name of Agency
Date	Date

Form No. DMB 234 (Rev. 1/96)
AUTHORITY: Act 431 of 1984
COMPLETION: Required
PENALTY: Contract will not be executed unless form is filed

STATE OF MICHIGAN
DEPARTMENT OF MANAGEMENT AND BUDGET **August 28, 2009**
PURCHASING OPERATIONS
P.O. BOX 30026, LANSING, MI 48909
OR
530 W. ALLEGAN, LANSING, MI 48933

NOTICE
TO
CONTRACT NO. 071B9200301
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF CONTRACTOR	TELEPHONE (517) 853-2574 **Deborah Freeland**
Clifton Gunderson LLP **120 N. Washington Square, Suite 805** **Lansing, MI 48933** **Deb.Freeland@cliftoncpa.com**	BUYER/CA (517) 241 -0684 **Brian Kloeckner**
Contract Compliance Inspector: Laura Dotson (517) 241-4686 **Annual Reports & Audits for Disproportionate Share Hospital Medicaid Program - DCH**	
CONTRACT PERIOD From: **September 1, 2009** To: **September 30, 2014**	
TERMS **N/A**	SHIPMENT **N/A**
F.O.B. **N/A**	SHIPPED FROM **N/A**
MINIMUM DELIVERY REQUIREMENTS **N/A**	

The terms and conditions of this Contract are those of RFP #071I9200194, this Contract Agreement and the vendor's quote dated June 10, 2009. In the event of any conflicts between the specifications, and terms and conditions, indicated by the State and those indicated by the vendor, those of the State take precedence.

Current Authorized Spend Limit: $1,955,480.00

Form No. DMB 234 (Rev. 1/96)
AUTHORITY: Act 431 of 1984
COMPLETION: Required
PENALTY: Contract will not be executed unless form is filed

STATE OF MICHIGAN
DEPARTMENT OF MANAGEMENT AND BUDGET
PURCHASING OPERATIONS
P.O. BOX 30026, LANSING, MI 48909
OR
530 W. ALLEGAN, LANSING, MI 48933

CONTRACT NO. 071B9200301

between

THE STATE OF MICHIGAN

and

NAME & ADDRESS OF CONTRACTOR	TELEPHONE (517) 853-2574 **Deborah Freeland**
Clifton Gunderson LLP **120 N. Washington Square, Suite 805** **Lansing, MI 48933** **Deb.Freeland@cliftoncpa.com**	BUYER/CA (517) 241 -0684 **Brian Kloeckner**
Contract Compliance Inspector: Laura Dotson (517) 241-4686 **Annual Reports & Audits for Disproportionate Share Hospital Medicaid Program - DCH**	
CONTRACT PERIOD From: **September 1, 2009** To: **September 30, 2014**	
TERMS **N/A**	SHIPMENT **N/A**
F.O.B. **N/A**	SHIPPED FROM **N/A**
MINIMUM DELIVERY REQUIREMENTS **N/A**	

MISCELLANEOUS INFORMATION:

The terms and conditions of this Contract are those of RFP #071I9200194, this Contract Agreement and the vendor's quote dated June 10, 2009. In the event of any conflicts between the specifications, and terms and conditions, indicated by the State and those indicated by the vendor, those of the State take precedence.

Current Authorized Spend Limit: $1,955,480.00

THIS IS NOT AN ORDER: This Contract Agreement is awarded on the basis of our inquiry bearing the RFP No. 071I9200194. Orders for delivery may be issued directly by the Department of Community Health through the issuance of a Purchase Order Form.

FOR THE CONTRACTOR:	**FOR THE STATE:**
Clifton Gunderson LLP Firm Name	Signature
Authorized Agent Signature	**Melissa Castro, Buyer Manager** Name/Title
Authorized Agent (Print or Type)	**Service Division, Purchasing Operations** Division
Date	Date

STATE OF MICHIGAN
Department of Management and Budget
Purchasing Operations

Contract No. 071B9200301

Annual Reports & Audits for Disproportionate
Share Hospital Medicaid Program

Buyer Name: Brian Kloeckner
Telephone Number: (517) 241-0684
E-Mail Address: kloecknerb@michigan.gov

Table of Contents

ATTACHMENTS:

DEFINITIONS

"Days" means calendar days unless otherwise specified.

"24x7x365" means 24 hours a day, seven days a week, and 365 days a year (including the 366th day in a leap year).

"Additional Service" means any Services/Deliverables within the scope of the Contract, but not specifically provided under any Statement of Work, that once added will result in the need to provide the Contractor with additional consideration.

"Audit Period" has the meaning given in **Section 2.112.**

"Business Day," whether capitalized or not, shall mean any day other than a Saturday, Sunday or State-recognized legal holiday (as identified in the Collective Bargaining Agreement for State employees) from 8:00am EST through 5:00pm EST unless otherwise stated.

"Blanket Purchase Order" is an alternate term for Contract and is used in the States computer system.

"Business Critical" means any function identified in any Statement of Work as Business Critical.

"Chronic Failure" is defined in any applicable Service Level Agreements.

"Deleted – Not Applicable" means that section is not applicable or included in this Contract. This is used as a placeholder to maintain consistent numbering.

"Deliverable" means physical goods and/or commodities as required or identified by a Statement of Work.

"DMB" means the Michigan Department of Management and Budget.

"Environmentally preferable products" means a product or service that has a lesser or reduced effect on human health and the environment when compared with competing products or services that serve the same purpose. Such products or services may include, but are not limited to, those which contain recycled content, minimize waste, conserve energy or water, and reduce the amount of toxics either disposed of or consumed.

"Excusable Failure" has the meaning given in **Section 2.244.**

"Hazardous material" means any material defined as hazardous under the latest version of federal Emergency Planning and Community Right-to-Know Act of 1986 (including revisions adopted during the term of the Contract).

"Incident" means any interruption in Services.

"Independent" means that the Single State Audit Agency or any other CPA firm that operates independently from the Medicaid agency or subject hospitals is eligible to perform the DSH audit. States may not rely on non-CPA firms, fiscal intermediaries acting as Agents for a State's Medicaid program, independent certification programs currently in place to audit uncompensated care costs, nor expand hospital financial statement to obtain audit certification of the hospital-specific DSH limits.

"Independent certified audit" means an audit that is conducted by an auditor that operates independently from the Medicaid agency or subject hospitals and is eligible to perform the DSH audit. Certification means that the independent auditor engaged by the State reviews the criteria of the Federal audit regulation and completes the verification, calculations and report under the professional rules and generally accepted standards of audit practice. This certification would include a review of the State's audit protocol to ensure that the Federal regulation is satisfied, an opinion for each verification detailed in the regulation, and a determination of whether or not the State made DSH payments that exceeded any hospital's specific DSH limit in the Medicaid State plan rate year under audit. The certification should also identify any data issues or other caveats that the auditor identified as impacting the results of the audit.

"ITB" is a generic term used to describe an Invitation to Bid. The ITB serves as the document for transmitting the RFP to potential bidders.

"Key Personnel" means any Personnel designated in **Section 1.031** as Key Personnel.

"New Work" means any Services/Deliverables outside the scope of the Contract and not specifically provided under any Statement of Work, that once added will result in the need to provide the Contractor with additional consideration.

"Ozone-depleting substance" means any substance the Environmental Protection Agency designates in 40 CFR part 82 as: (1) Class I, including, but not limited to, chlorofluorocarbons, halons, carbon tetrachloride, and methyl chloroform; or (2) Class II, including, but not limited to, hydrochlorofluorocarbons.

"Post-Consumer Waste" means any product generated by a business or consumer which has served its intended end use, and which has been separated or diverted from solid waste for the purpose of recycling into a usable commodity or product, and which does not include post-industrial waste.

"Post-Industrial Waste" means industrial by-products which would otherwise go to disposal and wastes generated after completion of a manufacturing process, but does not include internally generated scrap commonly returned to industrial or manufacturing processes.

"Recycling" means the series of activities by which materials that are no longer useful to the generator are collected, sorted, processed, and converted into raw materials and used in the production of new products. This definition excludes the use of these materials as a fuel substitute or for energy production.

"Reuse" means using a product or component of municipal solid waste in its original form more than once.

"RFP" means a Request for Proposal designed to solicit proposals for services.

"Services" means any function performed for the benefit of the State.

"Source reduction" means any practice that reduces the amount of any hazardous substance, pollutant, or contaminant entering any waste stream or otherwise released into the environment prior to recycling, energy recovery, treatment, or disposal.

"State Location" means any physical location where the State performs work. State Location may include state-owned, leased, or rented space.

"Subcontractor" means a company Contractor delegates performance of a portion of the Services to, but does not include independent contractors engaged by Contractor solely in a staff augmentation role.

"Unauthorized Removal" means the Contractor's removal of Key Personnel without the prior written consent of the State.

"Waste prevention" means source reduction and reuse, but not recycling.

"Waste reduction", or "pollution prevention" means the practice of minimizing the generation of waste at the source and, when wastes cannot be prevented, utilizing environmentally sound on-site or off-site reuse and recycling. The term includes equipment or technology modifications, process or procedure modifications, product reformulation or redesign, and raw material substitutions. Waste treatment, control, management, and disposal are not considered pollution prevention, per the definitions under Part 143, Waste Minimization, of the Natural Resources and Environmental Protection Act (NREPA), 1994 PA 451, as amended.

"Work in Progress" means a Deliverable that has been partially prepared, but has not been presented to the State for Approval.

"Work Product" refers to any data compilations, reports, and other media, materials, or other objects or works of authorship created or produced by the Contractor as a result of an in furtherance of performing the services required by this Contract.

Definitions Related Background/Scope of Work

"State Fiscal Year" (SFY) refers to the State Of Michigan Fiscal Year that runs from October 1st to September 30th of the given year.

"Independent audit'' means an audit conducted according to the standards specified in the generally accepted government auditing standards issued by the Comptroller General of the United States.

Article 1 – Statement of Work (SOW)

1.010 Project Identification

1.011 Project Request
This is a Contract for annual reports and independent audits of the Disproportionate Share Payments from the Michigan Medicaid Program per the attached specifications in Attachment B, C, and D for the Michigan Department of Community Health (MDCH), Actuarial Division.

1.012 Background
Title XIX of the Social Security Act (Act) authorizes Federal grants to States for Medicaid programs that provide medical assistance to low-income families, the elderly and persons with disabilities. Section 1902(a)(13)(A)(iv) of the Act requires that States make Medicaid payment adjustments for hospitals that serve a disproportionate share of low-income patients with special needs.

Section 1923 of the Act contains more specific requirements related to such Disproportionate Share Hospital (DSH) payments, including aggregate annual state-specific limits on Federal financial participation under Section 1923(f), and hospital-specific limits on DSH payments under Section 1923(g). Under those hospital specific limits, a hospital's DSH payments may not exceed the costs incurred by that hospital in furnishing services during the year to Medicaid patients and the uninsured, less other Medicaid payments made to the hospital, and payments made by uninsured patients ("uncompensated care costs"). In addition, Section 1923(a)(2)(D) requires States to provide an annual report to the Secretary describing the payment adjustments made to each disproportionate share hospital.

In addition to these reporting requirements, under Section 1923(j) of the Act, Federal matching payments are contingent upon a State's submission of the annual DSH report and independent certified audit.

CMS published a final rule on December 19, 2008 implementing the reporting and auditing requirements for State DSH payments under the State Medicaid program in the Federal Register (73 Fed. Reg.77904). The final rule was effective on January 19, 2009.

This final rule sets forth the data elements necessary to comply with the requirements of Section 1923(j) of the Social Security Act (Act) related to auditing and reporting of disproportionate share hospital payments under State Medicaid programs. These requirements were added by Section 1001(d) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).

The rule requires states to verify their methodology for computing the hospital specific DSH limit and the DSH payments made to hospitals. As required by Section 1923(j)(2) of the Act, these five items identified in statute would provide independent verification that State Medicaid DSH payments comply with the hospital-specific DSH limit in Section 1923(g) of the Act, and that such limits are accurately computed.

The rule adds a new Sec. 455.304(a) to reflect Section 1923(j) of the Act's requirement that each State must submit annually the independent certified audit of its DSH program as a condition for receiving Federal payments under Section 1903(a)(1) and 1923 of the Act.

The rule adds a new Sec. 455.304(b) to reflect the requirement that States must obtain an independent certified audit, beginning with an audit of its State fiscal year 2005 DSH program.

The rule requires that in the audit report, the auditor must verify whether the State's method of computing the hospital-specific DSH limit and the DSH payments made to the hospital comply with the five items required by Section 1923(j)(2) of the Act.

1.020 Scope of Work and Deliverables

1.021 In Scope
The Contractor must provide an annual report of the State's Disproportionate Share Hospital program to meet the following requirements in accordance with Attachment B:

Section 1001(d) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108-173, enacted on December 8, 2003) added Section 1923(j) to the Act to require States to report additional information about their DSH programs. Section 1923(j)(1) of the Act requires States to submit an annual report that includes the following:

*Identification of each DSH facility that received a DSH payment under the State's Medicaid program in the preceding fiscal year and the amount of DSH payments paid to that hospital in the same year.

*Such other information as the Secretary of Health and Human Services determines necessary to ensure the appropriateness of DSH payments.

The Contractor must conduct independent, certified audits of designated Medicaid State plan rate years of the Michigan Medicaid Program that provide Disproportionate Share Hospital Payments to Michigan hospitals eligible for such payments. Attachment D provides a list of Michigan Medicaid DSH eligible hospitals and DSH payments made for State FYs 2005 and 2006.

These independent, certified audits will be submitted by the State, in accordance with Section 1923(j)(2) of the Act, to the Secretary of Health and Human Services. The certified independent audit must verify:

1. The extent to which hospitals in the State have reduced uncompensated care costs to reflect the total amount of claimed expenditures made under Section 1923 of the Act.

2. DSH payments to each hospital comply with the applicable hospital-specific DSH payment limit.

3. Only the uncompensated care costs of providing inpatient hospital and outpatient hospital services to Medicaid eligible individuals and uninsured individuals as described in Section 1923(g)(1)(A) of the Act are included in the calculation of the hospital-specific limits.

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

5. The State has separately documented and retained a record of all its costs under the Medicaid program, claimed expenditures under the Medicaid program, uninsured costs in determining payment adjustments under Section 1923 of the Act, and any payments made on behalf of the uninsured from payment adjustments under Section 1923 of the Act.

1.022 Work and Deliverable

Contractor must provide Deliverables/Services and staff, and otherwise do all things necessary for or incidental to the performance of work as follows in accordance with Attachments B and C:

A. The Contractor must provide a report and conduct an audit of the Medicaid State plan rate year for the periods (1) October 1, 2004 through September 30, 2005 (Medicaid State fiscal year 2005); and, (2) October 1, 2005 through September 30, 2006 (Medicaid State fiscal year 2006). These audits must be completed and submitted to MDCH no later than September 30, 2009.

B. The Contractor must provide a report and conduct an audit of the Medicaid State plan rate year for the period October 1, 2006 through September 30, 2007 (Medicaid State fiscal year 2007). Report and audit must be completed and submitted to MDCH no later than September 30, 2010.

C. The Contractor must provide a report and conduct an audit of the Medicaid State plan rate year for the period October 1, 2007 through September 30, 2008 (Medicaid State fiscal year 2008). Report and audit must be completed and submitted to MDCH no later than September 30, 2011.

D. The Contractor must provide a report and conduct an audit of the Medicaid State plan rate year for the period October 1, 2008 through September 30, 2009 (Medicaid State fiscal year 2009). Report and audit must be completed and submitted to MDCH no later than September 30, 2012.

E. The Contractor must provide a report and conduct an audit of the Medicaid State plan rate year for the period October 1, 2009 through September 30, 2010 (Medicaid State fiscal year 2010). Report and audit must be completed and submitted to MDCH no later than September 30, 2013.

F. The Contractor must provide a report and conduct an audit of the Medicaid State plan rate year for the period October 1, 2010 through September 30, 2011 (Medicaid fiscal year 2011). Report and audit must be completed and submitted to MDCH no later than September 30, 2014.

The Contractor must submit an annual report and a complete, certified, independent audit for each Medicaid State plan year to MDCH by the following dates:

- Medicaid Plan years 2005 and 2006 must be submitted to MDCH no later than September 30, 2009.
- Medicaid Plan year 2007 must be submitted no later than September 30, 2010.
- Medicaid Plan year 2008 must be submitted no later than September 30, 2011.
- Medicaid Plan year 2009 must be submitted no later than September 30, 2012.
- Medicaid Plan year 2010 must be submitted no later than September 30, 2013.
- Medicaid Plan year 2011 must be submitted no later than September 30, 2014.

G. The Contractor must review State's methodology for estimating hospital's OBRA 1993 hospital-specific DSH limit and the State's DSH payment methodologies in the approved Medicaid State plan for the State plan rate year under audit.

H. The Contractor must review state's DSH audit protocol to ensure consistency with IP/OP Medicaid reimbursable services in the approved Medicaid State plan. Review DSH audit protocol to ensure that only costs eligible for DSH payments are included in the development of the hospital specific DSH limit.

I. The Contractor must compile hospital specific inpatient/outpatient cost report data and inpatient/outpatient revenue data to measure hospital specific DSH limit in auditable year. In determining this limit, the auditor must measure both components of the hospital specific DSH limit. To determine the existence of a Medicaid shortfall, Medicaid inpatient/outpatient hospital costs (including Medicaid managed care costs) must be measured against Medicaid inpatient/outpatient revenue received for such services in the audited State Plan rate year (including regular Medicaid rate payments, add-ons, supplemental and enhanced payments and Medicaid managed care revenues). Costs associated with patients with no source of third party coverage must be reduced by applicable revenues and added to any Medicaid shortfall to determine total eligible DSH costs.

J. The Contractor must compile total DSH payments made in auditable year to each qualifying hospital (including DSH payments received by the hospitals from other States).

K. The Contractor must compare hospital specific DSH costs limits against hospital specific total DSH payments in the audited Medicaid State plan rate year. Summarize findings identifying any overpayments/underpayments to particular hospitals.

. The Contractor may be required to travel on-site to Michigan DSH hospitals for additional information at no additional cost to the State.

1.030 Roles and Responsibilities

1.031 Contractor Staff, Roles, and Responsibilities

For purpose of this Contract, Key Personnel are defined as:

- Deb Freeland - Engagement Partner
- Emily Hess - Senior Manager
- JoAnn Mann-Beattie - Engagement Manager
- Bonnie Phillips - Manager
- Mark Hiltion - Subject Matter Expert
- W. David Mosley – Subject Matter Expert
- Hugh Webster – Subject Matter Expert
- David McMahon – Subject Matter Expert
- Walter Burgin – Senior Associate
- Samantha Guest – Senior Associate

- Michael Horoho – Senior Associate
- Allen Still – Senior Associate
- Gregory Turner – Senior Associate
- Joe Lackey – Senior Associate
- Nathan Salati - Associate

1.040 Project Plan

1.041 Project Plan Management
The Contractor may be asked to update the work plan prior to implementation and report any work plan modifications during the course of the project. Work plan updates and reports are to be submitted to Meghan Sifuentes of the Medical Services Administration of MDCH for approval.

1.042 Reports
MDCH requires that the Contractor must be able to submit a report on project status and progress according to the agreed upon reporting due dates, but at least on a monthly basis.

1.050 Acceptance

1.051 Criteria
The following criteria will be used by the State to determine Acceptance of the Services or Deliverables provided under this SOW:

A. Project Manager Responsibilities Related to Acceptance of Work and Deliverables

The Department's Project Manager will be responsible for verifying that the work:

a. Was performed in the time period referenced;
b. Meets the work or deliverable criteria; and
c. Was performed according to Contract specifications.

B. Approval Process of Work and Deliverables

Once the Department's Project Manager approves the deliverables invoices will be forwarded for additional review and payment to DCH Purchasing via the approval path. Approvals are tiered by signature authority congruent with the dollar amount of the invoice.

1.052 Final Acceptance – Deleted – Not Applicable

1.060 Proposal Pricing

1.061 Proposal Pricing
See Attachment A for pricing and quick payment terms.

Contractor's out-of-pocket expenses are not separately reimbursable by the State unless, on a case-by-case basis for unusual expenses, the State has agreed in advance and in writing to reimburse Contractor for the expense at the State's current travel reimbursement rates. See **www.michigan.gov/dmb** for current rates.

1.062 Price Term
(**x**) Firm Fixed Price

Prices quoted are firm for the entire length of the Contract.

1.063 Tax Excluded from Price
(a) Sales Tax: For purchases made directly by the State, the State is exempt from State and Local Sales Tax. Prices must not include the taxes. Exemption Certificates for State Sales Tax will be furnished upon request.

(b) Federal Excise Tax: The State may be exempt from Federal Excise Tax, or the taxes may be reimbursable, if articles purchased under any resulting Contract are used for the State's exclusive use. Certificates showing exclusive use for the purposes of substantiating a tax-free, or tax-reimbursable sale will be sent upon request. If a sale is tax exempt or tax reimbursable under the Internal Revenue Code, prices must not include the Federal Excise Tax.

1.064 Holdback- Deleted – Not Applicable

1.070 Additional Requirements-Deleted – Not Applicable

Article 2, Terms and Conditions

2.000 Contract Structure and Term

2.001 Contract Term
This Contract is for a period of five years beginning September 1, 2009 through September 30, 2014. All outstanding Purchase Orders must also expire upon the termination (cancellation for any of the reasons listed in **Section 2.150**) of the Contract, unless otherwise extended under the Contract. Absent an early termination for any reason, Purchase Orders issued but not expired, by the end of the Contract's stated term, will remain in effect for the balance of the fiscal year for which they were issued.

2.002 Options to Renew
This Contract may be renewed in writing by mutual agreement of the parties not less than 30 days before its expiration. The Contract may be renewed for up to two additional one year periods.

2.003 Legal Effect
Contractor shall show acceptance of this Contract by signing two copies of the Contract and returning them to the Contract Administrator. The Contractor shall not proceed with the performance of the work to be done under the Contract, including the purchase of necessary materials, until both parties have signed the Contract to show acceptance of its terms, and the Contractor receives a contract release/purchase order that authorizes and defines specific performance requirements.

Except as otherwise agreed in writing by the parties, the State assumes no liability for costs incurred by Contractor or payment under this Contract, until Contractor is notified in writing that this Contract (or Change Order) has been approved by the State Administrative Board (if required), approved and signed by all the parties, and a Purchase Order against the Contract has been issued.

2.004 Attachments & Exhibits
All Attachments and Exhibits affixed to any and all Statement(s) of Work, or appended to or referencing this Contract, are incorporated in their entirety and form part of this Contract.

2.005 Ordering
The State will issue a written Purchase Order, Blanket Purchase Order, Direct Voucher or Procurement Card Order, which must be approved by the Contract Administrator or the Contract Administrator's designee, to order any Services/Deliverables under this Contract. All orders are subject to the terms and conditions of this Contract. No additional terms and conditions contained on either a Purchase Order or Blanket Purchase Order apply unless they are also specifically contained in that Purchase Order's or Blanket Purchase Order's accompanying Statement of Work. Exact quantities to be purchased are unknown, however, the Contractor will be required to furnish all such materials and services as may be ordered during the CONTRACT period. Quantities specified, if any, are estimates based on prior purchases, and the State is not obligated to purchase in these or any other quantities.

2.006 Order of Precedence
(a) The Contract, including any Statements of Work and Exhibits, to the extent not contrary to the Contract, each of which is incorporated for all purposes, constitutes the entire agreement between the parties with respect to the subject matter and supersedes all prior agreements, whether written or oral, with respect to the subject matter and as additional terms and conditions on the purchase order must apply as limited by **Section 2.005.**

(b) In the event of any inconsistency between the terms of the Contract and a Statement of Work, the terms of the Statement of Work will take precedence (as to that Statement of Work only); provided, however, that a Statement of Work may not modify or amend the terms of the Contract, which may be modified or amended only by a formal Contract amendment.

2.007 Headings
Captions and headings used in the Contract are for information and organization purposes. Captions and headings, including inaccurate references, do not, in any way, define or limit the requirements or terms and conditions of the Contract.

2.008 Form, Function & Utility
If the Contract is for use of more than one State agency and if the Deliverable/Service does not the meet the form, function, and utility required by that State agency, that agency may, subject to State purchasing policies, procure the Deliverable/Service from another source.

2.009 Reformation and Severability
Each provision of the Contract is severable from all other provisions of the Contract and, if one or more of the provisions of the Contract is declared invalid, the remaining provisions of the Contract remain in full force and effect.

2.010 Consents and Approvals
Except as expressly provided otherwise in the Contract, if either party requires the consent or approval of the other party for the taking of any action under the Contract, the consent or approval must be in writing and must not be unreasonably withheld or delayed.

2.011 No Waiver of Default
If a party fails to insist upon strict adherence to any term of the Contract then the party has not waived the right to later insist upon strict adherence to that term, or any other term, of the Contract.

2.012 Survival
Any provisions of the Contract that impose continuing obligations on the parties, including without limitation the parties' respective warranty, indemnity and confidentiality obligations, survive the expiration or termination of the Contract for any reason. Specific references to survival in the Contract are solely for identification purposes and not meant to limit or prevent the survival of any other section.

2.020 Contract Administration

2.021 Issuing Office
This Contract is issued by the Department of Management and Budget, Purchasing Operations and [Department of Community Health](MDCH) (collectively, including all other relevant State of Michigan departments and agencies, the "State"). Purchasing Operations is the sole point of contact in the State with regard to all procurement and contractual matters relating to the Contract. Purchasing Operations **is the only State office authorized to change, modify, amend, alter or clarify the prices, specifications, terms and conditions of this Contract.** The Contractor Administrator within Purchasing Operations for this Contract is:

Brian Kloeckner
Purchasing Operations
Department of Management and Budget
Mason Bldg, 2nd Floor
PO Box 30026
Lansing, MI 48909
(517) 241-0684 - kloecknerb@michigan.gov

2.022 Contract Compliance Inspector (CCI)
After DMB-Purchasing Operations receives the properly executed Contract, it is anticipated that the Director of Purchasing Operations, in consultation with the Department of Community Health, will direct the person named below, or any other person so designated, to monitor and coordinate the activities for the Contract on a day-to-day basis during its term. However, monitoring of this Contract implies **no authority to change, modify, clarify, amend, or otherwise alter the prices, terms, conditions and specifications of the Contract as that authority is retained by DMB Purchasing Operations**. The Contract Compliance Inspector for this Contract is:

Laura Dotson, Unit Manager
Administrative Contract Services Unit
Michigan Department of Community Health
Contract Management Section
320 S. Walnut Street
Email: DotsonL1@michigan.gov
Phone (517) 241-4686
Fax (517) 241-4845

2.023 Project Manager

The following individuals will oversee the project:

Meghan Sifuentes, Policy Analyst
Department of Community Health
Capitol Commons Complex, 7th Floor
P.O. Box 30479
Email: Sifuentesm@michigan.gov
Phone (517) 241-7541
Fax (517) 241-5112

Richard Miles, Actuarial Division Director
Department of Community Health
Capital Commons Complex, 7th Floor
PO Box 30479
Email miles@michigan.gov
Phone 517-373-2378
Fax 517-241-5112

2.024 Change Requests

The State reserves the right to request from time to time any changes to the requirements and specifications of the Contract and the work to be performed by the Contractor under the Contract. During the course of ordinary business, it may become necessary for the State to discontinue certain business practices or create Additional Services/Deliverables. At a minimum, to the extent applicable, the State would like the Contractor to provide a detailed outline of all work to be done, including tasks necessary to accomplish the services/deliverables, timeframes, listing of key personnel assigned, estimated hours for each individual per task, and a complete and detailed cost justification.

If the Contractor does not so notify the State, the Contractor has no right to claim thereafter that it is entitled to additional compensation for performing that service or providing that deliverable.

Change Requests:

(a) By giving Contractor written notice within a reasonable time, the State must be entitled to accept a Contractor proposal for Change, to reject it, or to reach another agreement with Contractor. Should the parties agree on carrying out a Change, a written Contract Change Notice must be prepared and issued under this Contract, describing the Change and its effects on the Services and any affected components of this Contract (a "Contract Change Notice").

(b) No proposed Change may be performed until the proposed Change has been specified in a duly executed Contract Change Notice issued by the Department of Management and Budget, Purchasing Operations.

(c) If the State requests or directs the Contractor to perform any activities that Contractor believes constitute a Change, the Contractor must notify the State that it believes the requested activities are a Change before beginning to work on the requested activities. If the Contractor fails to notify the State before beginning to work on the requested activities, then the Contractor waives any right to assert any claim for additional compensation or time for performing the requested activities. If the Contractor commences performing work outside the scope of this Contract and then ceases performing that work, the Contractor must, at the request of the State, retract any out-of-scope work that would adversely affect the Contract.

2.025 Notices

Any notice given to a party under the Contract must be deemed effective, if addressed to the party as addressed below, upon: (i) delivery, if hand delivered; (ii) receipt of a confirmed transmission by facsimile if a copy of the notice is sent by another means specified in this Section; (iii) the third Business Day after being sent by U.S. mail, postage pre-paid, return receipt requested; or (iv) the next Business Day after being sent by a nationally recognized overnight express courier with a reliable tracking system.

State:
State of Michigan
Purchasing Operations
Attention: Brian Kloeckner
PO Box 30026
530 West Allegan
Lansing, Michigan 48909

Contractor:
Clifton Gunderson LLP
Deborah Freeland
120 North Washington Street, Suite 805
Lansing, MI 48933

Either party may change its address where notices are to be sent by giving notice according to this Section.

2.026 Binding Commitments
Representatives of Contractor must have the authority to make binding commitments on Contractor's behalf within the bounds set forth in this Contract. Contractor may change the representatives from time to time upon written notice.

2.027 Relationship of the Parties
The relationship between the State and Contractor is that of client and independent contractor. No agent, employee, or servant of Contractor or any of its Subcontractors must be or must be deemed to be an employee, agent or servant of the State for any reason. Contractor will be solely and entirely responsible for its acts and the acts of its agents, employees, servants and Subcontractors during the performance of the Contract.

2.028 Covenant of Good Faith
Each party must act reasonably and in good faith. Unless stated otherwise in the Contract, the parties will not unreasonably delay, condition or withhold the giving of any consent, decision or approval that is either requested or reasonably required of them in order for the other party to perform its responsibilities under the Contract.

2.029 Assignments
(a) Neither party may assign the Contract, or assign or delegate any of its duties or obligations under the Contract, to any other party (whether by operation of law or otherwise), without the prior written consent of the other party; provided, however, that the State may assign the Contract to any other State agency, department, division or department without the prior consent of Contractor and Contractor may assign the Contract to an affiliate so long as the affiliate is adequately capitalized and can provide adequate assurances that the affiliate can perform the Contract. The State may withhold consent from proposed assignments, subcontracts, or novations when the transfer of responsibility would operate to decrease the State's likelihood of receiving performance on the Contract or the State's ability to recover damages.

(b) Contractor may not, without the prior written approval of the State, assign its right to receive payments due under the Contract. If the State permits an assignment, the Contractor is not relieved of its responsibility to perform any of its contractual duties, and the requirement under the Contract that all payments must be made to one entity continues.

(c) If the Contractor intends to assign the contract or any of the Contractor's rights or duties under the Contract, the Contractor must notify the State in writing at least 90 days before the assignment. The Contractor also must provide the State with adequate information about the assignee within a reasonable amount of time before the assignment for the State to determine whether to approve the assignment.

2.030 General Provisions

2.031 Media Releases
News releases (including promotional literature and commercial advertisements) pertaining to the RFP and Contract or project to which it relates shall not be made without prior written State approval, and then only in accordance with the explicit written instructions from the State. No results of the activities associated with the RFP and Contract are to be released without prior written approval of the State and then only to persons designated.

2.032 Contract Distribution
Purchasing Operations retains the sole right of Contract distribution to all State agencies and local units of government unless other arrangements are authorized by Purchasing Operations.

2.033 Permits
Contractor must obtain and pay any associated costs for all required governmental permits, licenses and approvals for the delivery, installation and performance of the Services. The State must pay for all costs and expenses incurred in obtaining and maintaining any necessary easements or right of way.

2.034 Website Incorporation
The State is not bound by any content on the Contractor's website, even if the Contractor's documentation specifically referenced that content and attempts to incorporate it into any other communication, unless the State has actual knowledge of the content and has expressly agreed to be bound by it in a writing that has been manually signed by an authorized representative of the State.

2.035 Future Bidding Preclusion
Contractor acknowledges that, to the extent this Contract involves the creation, research, investigation or generation of a future RFP; it may be precluded from bidding on the subsequent RFP. The State reserves the right to disqualify any bidder if the State determines that the bidder has used its position (whether as an incumbent Contractor, or as a Contractor hired to assist with the RFP development, or as a Vendor offering free assistance) to gain a competitive advantage on the RFP.

2.036 Freedom of Information
All information in any proposal submitted to the State by Contractor and this Contract is subject to the provisions of the Michigan Freedom of Information Act, 1976 Public Act No. 442, as amended, MCL 15.231, et seq (the "FOIA").

2.037 Disaster Recovery
Contractor and the State recognize that the State provides essential services in times of natural or man-made disasters. Therefore, except as so mandated by Federal disaster response requirements, Contractor personnel dedicated to providing Services/Deliverables under this Contract will provide the State with priority service for repair and work around in the event of a natural or man-made disaster.

2.040 Financial Provisions

2.041 Fixed Prices for Services/Deliverables
Each Statement of Work or Purchase Order issued under this Contract shall specify (or indicate by reference to the appropriate Contract Exhibit) the firm, fixed prices for all Services/Deliverables, and the associated payment milestones and payment amounts. The State may make progress payments to the Contractor when requested as work progresses, as but not more frequently than monthly, in amounts approved by the Contract Administrator, after negotiation. Contractor must show verification of measurable progress at the time of requesting progress payments.

2.042 Adjustments for Reductions in Scope of Services/Deliverables
If the scope of the Services/Deliverables under any Statement of Work issued under this Contract is subsequently reduced by the State, the parties shall negotiate an equitable reduction in Contractor's charges under such Statement of Work commensurate with the reduction in scope.

2.043 Services/Deliverables Covered
For all Services/Deliverables to be provided by Contractor (and its Subcontractors, if any) under this Contract, the State shall not be obligated to pay any amounts in addition to the charges specified in this Contract.

2.044 Invoicing and Payment – In General
(a) Each Statement of Work issued under this Contract shall list (or indicate by reference to the appropriate Contract Exhibit) the prices for all Services/Deliverables, equipment and commodities to be provided, and the associated payment milestones and payment amounts.

(b) Each Contractor invoice will show details as to charges by Service/Deliverable component and location at a level of detail reasonably necessary to satisfy the State's accounting and charge-back requirements. Invoices for Services performed on a time and materials basis will show, for each individual, the number of hours of Services performed during the billing period, the billable skill/labor category for such person and the applicable hourly billing rate. Prompt payment by the State is contingent on the Contractor's invoices showing the amount owed by the State minus any holdback amount to be retained by the State in accordance with **Section 1.064**.

(c) Correct invoices will be due and payable by the State, in accordance with the State's standard payment procedure as specified in 1984 Public Act No. 279, MCL 17.51 et seq., within 45 days after receipt, provided the State determines that the invoice was properly rendered.

(d) All invoices should reflect actual work done. Specific details of invoices and payments will be agreed upon between the Contract Administrator and the Contractor after the proposed Contract Agreement has been signed and accepted by both the Contractor and the Director of Purchasing Operations, Department of Management & Budget. This activity will occur only upon the specific written direction from Purchasing Operations.

The specific payment schedule for any Contract(s) entered into, as the State and the Contractor(s) will mutually agree upon. The schedule should show payment amount and should reflect actual work done by the payment dates, less any penalty cost charges accrued by those dates. As a general policy statements shall be forwarded to the designated representative by the 15th day of the following month.

The State may make progress payments to the Contractor when requested as work progresses, not more frequently than monthly, in amounts approved by the Contract Administrator, after negotiation. Contractor must show verification of measurable progress at the time of requesting progress payments.

2.045 Pro-ration – Deleted – Not Applicable

2.046 Antitrust Assignment
The Contractor assigns to the State any claim for overcharges resulting from antitrust violations to the extent that those violations concern materials or services supplied by third parties to the Contractor, toward fulfillment of this Contract.

2.047 Final Payment
The making of final payment by the State to Contractor does not constitute a waiver by either party of any rights or other claims as to the other party's continuing obligations under the Contract, nor will it constitute a waiver of any claims by one party against the other arising from unsettled claims or failure by a party to comply with this Contract, including claims for Services and Deliverables not reasonably known until after acceptance to be defective or substandard. Contractor's acceptance of final payment by the State under this Contract shall constitute a waiver of all claims by Contractor against the State for payment under this Contract, other than those claims previously filed in writing on a timely basis and still unsettled.

2.048 Electronic Payment Requirement
Electronic transfer of funds is required for payments on State Contracts. Contractors are required to register with the State electronically at http://www.cpexpress.state.mi.us. As stated in Public Act 431 of 1984, all contracts that the State enters into for the purchase of goods and services shall provide that payment will be made by electronic fund transfer (EFT).

2.050 Taxes

2.051 Employment Taxes
Contractors are expected to collect and pay all applicable federal, state, and local employment taxes, including the taxes.

2.052 Sales and Use Taxes
Contractors are required to be registered and to remit sales and use taxes on taxable sales of tangible personal property or services delivered into the State. Contractors that lack sufficient presence in Michigan to be required to register and pay tax must do so as a volunteer.

This requirement extends to: (1) all members of any controlled group as defined in § 1563(a) of the Internal Revenue Code and applicable regulations of which the company is a member, and (2) all organizations under common control as defined in § 414(c) of the Internal Revenue Code and applicable regulations of which the company is a member that make sales at retail for delivery into the State are registered with the State for the collection and remittance of sales and use taxes. In applying treasury regulations defining "two or more trades or businesses under common control" the term "organization" means sole proprietorship, a partnership (as defined in § 701(a)(2) of the Internal Revenue Code), a trust, an estate, a corporation, or a limited liability company.

2.060 Contract Management

2.061 Contractor Personnel Qualifications

All persons assigned by Contractor to the performance of Services under this Contract must be employees of Contractor or its majority-owned (directly or indirectly, at any tier) subsidiaries (or a State-approved Subcontractor) and must be fully qualified to perform the work assigned to them. Contractor must include a similar provision in any subcontract entered into with a Subcontractor. For the purposes of this Contract, independent contractors engaged by Contractor solely in a staff augmentation role must be treated by the State as if they were employees of Contractor for this Contract only; however, the State understands that the relationship between Contractor and Subcontractor is an independent contractor relationship.

2.062 Contractor Key Personnel

(a) The Contractor must provide the Contract Administrator with the names of the Key Personnel.

(b) Key Personnel must be dedicated as defined in the Statement of Work to the Project for its duration in the applicable Statement of Work with respect to other individuals designated as Key Personnel for that Statement of Work.

(c) The State will have the right to recommend and approve in writing the initial assignment, as well as any proposed reassignment or replacement, of any Key Personnel. Before assigning an individual to any Key Personnel position, Contractor will notify the State of the proposed assignment, will introduce the individual to the appropriate State representatives, and will provide the State with a resume and any other information about the individual reasonably requested by the State. The State reserves the right to interview the individual before granting written approval. In the event the State finds a proposed individual unacceptable, the State will provide a written explanation including reasonable detail outlining the reasons for the rejection.

(d) Contractor must not remove any Key Personnel from their assigned roles on the Contract without the prior written consent of the State. The Contractor's removal of Key Personnel without the prior written consent of the State is an unauthorized removal ("Unauthorized Removal"). Unauthorized Removals does not include replacing Key Personnel for reasons beyond the reasonable control of Contractor, including illness, disability, leave of absence, personal emergency circumstances and resignation or for cause termination of the Key Personnel's employment. Unauthorized Removals does not include replacing Key Personnel because of promotions or other job movements allowed by Contractor personnel policies or Collective Bargaining Agreement(s) as long as the State receives prior written notice before shadowing occurs and Contractor provides 30 days of shadowing unless parties agree to a different time period. The Contractor with the State must review any Key Personnel replacements, and appropriate transition planning will be established. Any Unauthorized Removal may be considered by the State to be a material breach of the Contract, in respect of which the State may elect to exercise its termination and cancellation rights.

(e) The Contractor must notify the Contract Compliance Inspector and the Contract Administrator at least 10 business days before redeploying non-Key Personnel, who are dedicated to primarily to the Project, to other projects. If the State does not object to the redeployment by its scheduled date, the Contractor may then redeploy the non-Key Personnel.

2.063 Re-assignment of Personnel at the State's Request

The State reserves the right to require the removal from the Project of Contractor personnel found, in the judgment of the State, to be unacceptable. The State's request must be written with reasonable detail outlining the reasons for the removal request. Additionally, the State's request must be based on legitimate, good-faith reasons. Replacement personnel for the removed person must be fully qualified for the position. If the State exercises this right, and the Contractor cannot immediately replace the removed personnel, the State agrees to an equitable adjustment in schedule or other terms that may be affected by the State's required removal.

If any incident with removed personnel results in delay not reasonably anticipatable under the circumstances and which is attributable to the State, the applicable SLAs for the affected Service will not be counted for a time as agreed to by the parties.

2.064 Contractor Personnel Location
All staff assigned by Contractor to work on the Contract will perform their duties either primarily at Contractor's offices and facilities or at State facilities. Without limiting the generality of the foregoing, Key Personnel will, at a minimum, spend at least the amount of time on-site at State facilities as indicated in the applicable Statement of Work. Subject to availability, selected Contractor personnel may be assigned office space to be shared with State personnel.

2.065 Contractor Identification
Contractor employees must be clearly identifiable while on State property by wearing a State-issued badge, as required. Contractor employees are required to clearly identify themselves and the company they work for whenever making contact with State personnel by telephone or other means.

2.066 Cooperation with Third Parties
Contractor agrees to cause its personnel and the personnel of any Subcontractors to cooperate with the State and its agents and other contractors including the State's Quality Assurance personnel. As reasonably requested by the State in writing, the Contractor will provide to the State's agents and other contractors reasonable access to Contractor's Project personnel, systems and facilities to the extent the access relates to activities specifically associated with this Contract and will not interfere or jeopardize the safety or operation of the systems or facilities. The State acknowledges that Contractor's time schedule for the Contract is very specific and agrees not to unnecessarily or unreasonably interfere with, delay or otherwise impeded Contractor's performance under this Contract with the requests for access.

2.067 Contractor Return of State Equipment/Resources
The Contractor must return to the State any State-furnished equipment, facilities and other resources when no longer required for the Contract in the same condition as when provided by the State, reasonable wear and tear excepted.

2.068 Contract Management Responsibilities
The Contractor will be required to assume responsibility for all contractual activities, whether or not that Contractor performs them. Further, the State will consider the Contractor to be the sole point of contact with regard to contractual matters, including payment of any and all charges resulting from the anticipated Contract. If any part of the work is to be subcontracted, the Contract must include a list of Subcontractors, including firm name and address, contact person and a complete description of work to be subcontracted. The State reserves the right to approve Subcontractors and to require the Contractor to replace Subcontractors found to be unacceptable. The Contractor is totally responsible for adherence by the Subcontractor to all provisions of the Contract. Any change in Subcontractors must be approved by the State, in writing, prior to such change.

2.070 Subcontracting by Contractor

2.071 Contractor Full Responsibility
Contractor shall have full responsibility for the successful performance and completion of all of the Services and Deliverables. The State will consider Contractor to be the sole point of contact with regard to all contractual matters under this Contract, including payment of any and all charges for Services and Deliverables.

2.072 State Consent to Delegation
Contractor shall not delegate any duties under this Contract to a Subcontractor unless the Department of Management and Budget, Purchasing Operations has given written consent to such delegation. The State shall have the right of prior written approval of all Subcontractors and to require Contractor to replace any Subcontractors found, in the reasonable judgment of the State, to be unacceptable. The State's request shall be written with reasonable detail outlining the reasons for the removal request. Additionally, the State's request shall be based on legitimate, good-faith reasons. Replacement Subcontractor(s) for the removed Subcontractor shall be fully qualified for the position. If the State exercises this right, and the Contractor cannot immediately replace the removed Subcontractor, the State will agree to an equitable adjustment in schedule or other terms that may be affected by the State's required removal. If any such incident with a removed Subcontractor results in delay not reasonable anticipatable under the circumstances and which is attributable to the State, the applicable SLA for the affected Work will not be counted for a time agreed upon by the parties.

2.073 Subcontractor Bound to Contract
In any subcontracts entered into by Contractor for the performance of the Services, Contractor shall require the Subcontractor, to the extent of the Services to be performed by the Subcontractor, to be bound to Contractor by the terms of this Contract and to assume toward Contractor all of the obligations and responsibilities that Contractor, by this Contract, assumes toward the State. The State reserves the right to receive copies of and review all subcontracts, although Contractor may delete or mask any proprietary information, including pricing, contained in such contracts before providing them to the State. The management of any Subcontractor will be the responsibility of Contractor, and Contractor shall remain responsible for the performance of its Subcontractors to the same extent as if Contractor had not subcontracted such performance. Contractor shall make all payments to Subcontractors or suppliers of Contractor. Except as otherwise agreed in writing by the State and Contractor, the State will not be obligated to direct payments for the Services other than to Contractor. The State's written approval of any Subcontractor engaged by Contractor to perform any obligation under this Contract shall not relieve Contractor of any obligations or performance required under this Contract.

2.074 Flow Down
Except where specifically approved in writing by the State on a case-by-case basis, Contractor shall flow down the obligations in **Sections 2.031, 2.060, 2.100, 2.110, 2.120, 2.130, 2.200** in all of its agreements with any Subcontractors.

2.075 Competitive Selection
The Contractor shall select subcontractors (including suppliers) on a competitive basis to the maximum practical extent consistent with the objectives and requirements of the Contract.

2.080 State Responsibilities – Deleted – Not Applicable

2.090 Security

2.091 Background Checks
On a case-by-case basis, the State may investigate the Contractor's personnel before they may have access to State facilities and systems. The scope of the background check is at the discretion of the State and the results will be used to determine Contractor personnel eligibility for working within State facilities and systems. The investigations will include Michigan State Police Background checks (ICHAT) and may include the National Crime Information Center (NCIC) Finger Prints. Proposed Contractor personnel may be required to complete and submit an RI-8 Fingerprint Card for the NCIC Finger Print Check. Any request for background checks will be initiated by the State and will be reasonably related to the type of work requested.

All Contractor personnel will also be expected to comply with the State's security and acceptable use policies for State IT equipment and resources. See http://www.michigan.gov/dit. Furthermore, Contractor personnel will be expected to agree to the State's security and acceptable use policies before the Contractor personnel will be accepted as a resource to perform work for the State. It is expected the Contractor will present these documents to the prospective employee before the Contractor presents the individual to the State as a proposed resource. Contractor staff will be expected to comply with all Physical Security procedures in place within the facilities where they are working.

2.092 Security Breach Notification
If the Contractor breaches this Section, the Contractor must (i) promptly cure any deficiencies and (ii) comply with any applicable federal and state laws and regulations pertaining to unauthorized disclosures. Contractor and the State will cooperate to mitigate, to the extent practicable, the effects of any breach, intrusion, or unauthorized use or disclosure. Contractor must report to the State in writing any use or disclosure of Confidential Information, whether suspected or actual, other than as provided for by the Contract within 10 days of becoming aware of the use or disclosure or the shorter time period as is reasonable under the circumstances.

2.093 PCI Data Security Requirements-Deleted – Not Applicable

2.100 Confidentiality

2.101 Confidentiality

Contractor and the State each acknowledge that the other possesses and will continue to possess confidential information that has been developed or received by it. As used in this Section, "Confidential Information" of Contractor must mean all non-public proprietary information of Contractor (other than Confidential Information of the State as defined below) which is marked confidential, restricted, proprietary or with a similar designation. "Confidential Information" of the State must mean any information which is retained in confidence by the State (or otherwise required to be held in confidence by the State under applicable federal, state and local laws and regulations) or which, in the case of tangible materials provided to Contractor by the State under its performance under this Contract, is marked as confidential, proprietary or with a similar designation by the State. "Confidential Information" excludes any information (including this Contract) that is publicly available under the Michigan FOIA.

2.102 Protection and Destruction of Confidential Information

The State and Contractor will each use at least the same degree of care to prevent disclosing to third parties the Confidential Information of the other as it employs to avoid unauthorized disclosure, publication or dissemination of its own confidential information of like character, but in no event less than reasonable care. Neither Contractor nor the State will (i) make any use of the Confidential Information of the other except as contemplated by this Contract, (ii) acquire any right in or assert any lien against the Confidential Information of the other, or (iii) if requested to do so, refuse for any reason to promptly return the other party's Confidential Information to the other party. Each party will limit disclosure of the other party's Confidential Information to employees and Subcontractors who must have access to fulfill the purposes of this Contract. Disclosure to, and use by, a Subcontractor is permissible where (A) use of a Subcontractor is authorized under this Contract, (B) the disclosure is necessary or otherwise naturally occurs in connection with work that is within the Subcontractor's scope of responsibility, and (C) Contractor obligates the Subcontractor in a written Contract to maintain the State's Confidential Information in confidence. At the State's request, any employee of Contractor and of any Subcontractor having access or continued access to the State's Confidential Information may be required to execute an acknowledgment that the employee has been advised of Contractor's and the Subcontractor's obligations under this Section and of the employee's obligation to Contractor or Subcontractor, as the case may be, to protect the Confidential Information from unauthorized use or disclosure.

Promptly upon termination or cancellation of the Contract for any reason, Contractor must certify to the State that Contractor has destroyed all State Confidential Information.

2.103 Exclusions

Notwithstanding the foregoing, the provisions of **Section 2.100** will not apply to any particular information which the State or Contractor can demonstrate (i) was, at the time of disclosure to it, in the public domain; (ii) after disclosure to it, is published or otherwise becomes part of the public domain through no fault of the receiving party; (iii) was in the possession of the receiving party at the time of disclosure to it without an obligation of confidentiality; (iv) was received after disclosure to it from a third party who had a lawful right to disclose the information to it without any obligation to restrict its further disclosure; or (v) was independently developed by the receiving party without reference to Confidential Information of the furnishing party. Further, the provisions of **Section 2.100** will not apply to any particular Confidential Information to the extent the receiving party is required by law to disclose the Confidential Information, provided that the receiving party (i) promptly provides the furnishing party with notice of the legal request, and (ii) assists the furnishing party in resisting or limiting the scope of the disclosure as reasonably requested by the furnishing party.

2.104 No Implied Rights

Nothing contained in this Section must be construed as obligating a party to disclose any particular Confidential Information to the other party, or as granting to or conferring on a party, expressly or impliedly, any right or license to the Confidential Information of the other party.

2.105 Respective Obligations

The parties' respective obligations under this Section must survive the termination or expiration of this Contract for any reason.

2.110 Records and Inspections

2.111 Inspection of Work Performed
The State's authorized representatives must at all reasonable times and with ten (10) days prior written request, have the right to enter Contractor's premises, or any other places, where the Services are being performed, and must have access, upon reasonable request, to interim drafts of Deliverables or work-in-progress. Upon 10 Days prior written notice and at all reasonable times, the State's representatives must be allowed to inspect, monitor, or otherwise evaluate the work being performed and to the extent that the access will not reasonably interfere or jeopardize the safety or operation of the systems or facilities. Contractor must provide all reasonable facilities and assistance for the State's representatives.

2.112 Examination of Records
For seven years after the Contractor provides any work under this Contract (the "Audit Period"), the State may examine and copy any of Contractor's books, records, documents and papers pertinent to establishing Contractor's compliance with the Contract and with applicable laws and rules. The State must notify the Contractor 20 days before examining the Contractor's books and records. The State does not have the right to review any information deemed confidential by the Contractor to the extent access would require the confidential information to become publicly available. This provision also applies to the books, records, accounts, documents and papers, in print or electronic form, of any parent, affiliated or subsidiary organization of Contractor, or any Subcontractor of Contractor performing services in connection with the Contract.

2.113 Retention of Records
Contractor must maintain at least until the end of the Audit Period all pertinent financial and accounting records (including time sheets and payroll records, and information pertaining to the Contract and to the Services, equipment, and commodities provided under the Contract) pertaining to the Contract according to generally accepted accounting principles and other procedures specified in this Section. Financial and accounting records must be made available, upon request, to the State at any time during the Audit Period. If an audit, litigation, or other action involving Contractor's records is initiated before the end of the Audit Period, the records must be retained until all issues arising out of the audit, litigation, or other action are resolved or until the end of the Audit Period, whichever is later.

2.114 Audit Resolution
If necessary, the Contractor and the State will meet to review each audit report promptly after issuance. The Contractor will respond to each audit report in writing within 30 days from receipt of the report, unless a shorter response time is specified in the report. The Contractor and the State must develop, agree upon and monitor an action plan to promptly address and resolve any deficiencies, concerns, and/or recommendations in the audit report.

2.115 Errors
(a) If the audit demonstrates any errors in the documents provided to the State, then the amount in error must be reflected as a credit or debit on the next invoice and in subsequent invoices until the amount is paid or refunded in full. However, a credit or debit may not be carried for more than four invoices. If a balance remains after four invoices, then the remaining amount will be due as a payment or refund within 45 days of the last quarterly invoice that the balance appeared on or termination of the Contract, whichever is earlier.

(b) In addition to other available remedies, the difference between the payment received and the correct payment amount is greater than 10%, then the Contractor must pay all of the reasonable costs of the audit.

2.120 Warranties

2.121 Warranties and Representations
The Contractor represents and warrants:

(a) It is capable in all respects of fulfilling and must fulfill all of its obligations under this Contract. The performance of all obligations under this Contract must be provided in a timely, professional, and workman-like manner and must meet the performance and operational standards required under this Contract.

(b) The Contract Appendices, Attachments and Exhibits identify the equipment and software and services necessary for the Deliverable(s) to perform and Services to operate in compliance with the Contract's requirements and other standards of performance.

(c) It is the lawful owner or licensee of any Deliverable licensed or sold to the State by Contractor or developed by Contractor under this Contract, and Contractor has all of the rights necessary to convey to the State the ownership rights or licensed use, as applicable, of any and all Deliverables. None of the Deliverables provided by Contractor to the State under this Contract, nor their use by the State, will infringe the patent, copyright, trade secret, or other proprietary rights of any third party.

(d) If, under this Contract, Contractor procures any equipment, software or other Deliverable for the State (including equipment, software and other Deliverables manufactured, re-marketed or otherwise sold by Contractor under Contractor's name), then in addition to Contractor's other responsibilities with respect to the items in this Contract, Contractor must assign or otherwise transfer to the State or its designees, or afford the State the benefits of, any manufacturer's warranty for the Deliverable.

(e) The contract signatory has the power and authority, including any necessary corporate authorizations, necessary to enter into this Contract, on behalf of Contractor.

(f) It is qualified and registered to transact business in all locations where required.

(g) Neither the Contractor nor any Affiliates, nor any employee of either, has, must have, or must acquire, any contractual, financial, business, or other interest, direct or indirect, that would conflict in any manner or degree with Contractor's performance of its duties and responsibilities to the State under this Contract or otherwise create an appearance of impropriety with respect to the award or performance of this Agreement. Contractor must notify the State about the nature of the conflict or appearance of impropriety within two days of learning about it.

(h) Neither Contractor nor any Affiliates, nor any employee of either has accepted or must accept anything of value based on an understanding that the actions of the Contractor or Affiliates or employee on behalf of the State would be influenced. Contractor must not attempt to influence any State employee by the direct or indirect offer of anything of value.

(i) Neither Contractor nor any Affiliates, nor any employee of either has paid or agreed to pay any person, other than bona fide employees and consultants working solely for Contractor or the Affiliate, any fee, commission, percentage, brokerage fee, gift, or any other consideration, contingent upon or resulting from the award or making of this Contract.

(j) The prices proposed by Contractor were arrived at independently, without consultation, communication, or agreement with any other bidder for the purpose of restricting competition; the prices quoted were not knowingly disclosed by Contractor to any other bidder; and no attempt was made by Contractor to induce any other person to submit or not submit a proposal for the purpose of restricting competition.

(k) All financial statements, reports, and other information furnished by Contractor to the State as part of its response to the RFP or otherwise in connection with the award of this Contract fairly and accurately represent the business, properties, financial condition, and results of operations of Contractor as of the respective dates, or for the respective periods, covered by the financial statements, reports, other information. Since the respective dates or periods covered by the financial statements, reports, or other information, there have been no material adverse change in the business, properties, financial condition, or results of operations of Contractor.

(l) All written information furnished to the State by or for the Contractor in connection with this Contract, including its bid, is true, accurate, and complete, and contains no untrue statement of material fact or omits any material fact necessary to make the information not misleading.

(m) It is not in material default or breach of any other contract or agreement that it may have with the State or any of its departments, commissions, boards, or agencies. Contractor further represents and warrants that it has not been a party to any contract with the State or any of its departments that was terminated by the State or the department within the previous five years for the reason that Contractor failed to perform or otherwise breached an obligation of the Contract.

(n) If any of the certifications, representations, or disclosures made in the Contractor's original bid response change after contract award, the Contractor is required to report those changes immediately to the Department of Management and Budget, Purchasing Operations.

2.122 Warranty of Merchantability – Deleted – Not Applicable

2.123 Warranty of Fitness for a Particular Purpose – Deleted – Not Applicable

2.124 Warranty of Title – Deleted – Not Applicable

2.125 Equipment Warranty- Deleted – Not Applicable

2.126 Equipment to be New- Deleted – Not Applicable

2.127 Prohibited Products- Deleted – Not Applicable

2.128 Consequences For Breach
In addition to any remedies available in law, if the Contractor breaches any of the warranties contained in this section, the breach may be considered as a default in the performance of a material obligation of this Contract.

2.130 Insurance

2.131 Liability Insurance
The Contractor must provide proof of the minimum levels of insurance coverage as indicated below. The insurance must protect the State from claims which may arise out of or result from the Contractor's performance of services under the terms of this Contract, whether the services are performed by the Contractor, or by any subcontractor, or by anyone directly or indirectly employed by any of them, or by anyone for whose acts they may be liable.

The Contractor waives all rights against the State of Michigan, its departments, divisions, agencies, offices, commissions, officers, employees and agents for recovery of damages to the extent these damages are covered by the insurance policies the Contractor is required to maintain under this Contract.

All insurance coverage's provided relative to this Contract/Purchase Order are PRIMARY and NON-CONTRIBUTING to any comparable liability insurance (including self-insurances) carried by the State.

The insurance must be written for not less than any minimum coverage specified in this Contract or required by law, whichever is greater.

The insurers selected by Contractor must have an A.M. Best rating of A or better, or as otherwise approved in writing by the State, or if the ratings are no longer available, with a comparable rating from a recognized insurance rating agency. All policies of insurance required in this Contract must be issued by companies that have been approved to do business in the State.
See www.michigan.gov/dleg.

Where specific limits are shown, they are the minimum acceptable limits. If Contractor's policy contains higher limits, the State must be entitled to coverage to the extent of the higher limits.

The Contractor is required to pay for and provide the type and amount of insurance checked ☑ below:

☑ 1. Commercial General Liability with the following minimum coverage:

$2,000,000 General Aggregate Limit other than Products/Completed Operations
$2,000,000 Products/Completed Operations Aggregate Limit
$1,000,000 Personal & Advertising Injury Limit
$1,000,000 Each Occurrence Limit

The Contractor must list the State of Michigan, its departments, divisions, agencies, offices, commissions, officers, employees and agents as ADDITIONAL INSUREDS on the Commercial General Liability certificate. The Contractor also agrees to provide evidence that insurance policies contain a waiver of subrogation by the insurance company.

☑ 2. If a motor vehicle is used to provide services or products under this Contract, the Contractor must have vehicle liability insurance on any auto including owned, hired and non-owned vehicles used in Contractor's business for bodily injury and property damage as required by law.

The Contractor must list the State of Michigan, its departments, divisions, agencies, offices, commissions, officers, employees and agents as ADDITIONAL INSUREDS on the vehicle liability certificate. The Contractor also agrees to provide evidence that insurance policies contain a waiver of subrogation by the insurance company.

☑ 3. Workers' compensation coverage must be provided according to applicable laws governing the employees and employers work activities in the state of the Contractor's domicile. If the applicable coverage is provided by a self-insurer, proof must be provided of approved self-insured authority by the jurisdiction of domicile. For employees working outside of the state of qualification, Contractor must provide appropriate certificates of insurance proving mandated coverage levels for the jurisdictions where the employees' activities occur.

Any certificates of insurance received must also provide a list of states where the coverage is applicable.

The Contractor also agrees to provide evidence that insurance policies contain a waiver of subrogation by the insurance company. This provision must not be applicable where prohibited or limited by the laws of the jurisdiction in which the work is to be performed.

☑ 4. Employers liability insurance with the following minimum limits:

$100,000 each accident
$100,000 each employee by disease
$500,000 aggregate disease

☐ 5. Employee Fidelity, including Computer Crimes, insurance naming the State as a loss payee, providing coverage for direct loss to the State and any legal liability of the State arising out of or related to fraudulent or dishonest acts committed by the employees of Contractor or its Subcontractors, acting alone or in collusion with others, in a minimum amount of one million dollars ($1,000,000.00) with a maximum deductible of fifty thousand dollars ($50,000.00).

☐ 6. Umbrella or Excess Liability Insurance in a minimum amount of ten million dollars ($10,000,000.00), which must apply, at a minimum, to the insurance required in Subsection 1 (Commercial General Liability) above.

☐ 7. Professional Liability (Errors and Omissions) Insurance with the following minimum coverage: three million dollars ($3,000,000.00) each occurrence and three million dollars ($3,000,000.00) annual aggregate.

☐ 8. Fire and Personal Property Insurance covering against any loss or damage to the office space used by Contractor for any reason under this Contract, and the equipment, software and other contents of the office space, including without limitation, those contents used by Contractor to provide the Services to the State, up to its replacement value, where the office space and its contents are under the care, custody and control of Contractor. The policy must cover all risks of direct physical loss or damage, including without limitation, flood and earthquake coverage and coverage for computer hardware and software. The State must be endorsed on the policy as a loss payee as its interests appear.

2.132 Subcontractor Insurance Coverage

Except where the State has approved in writing a Contractor subcontract with other insurance provisions, Contractor must require all of its Subcontractors under this Contract to purchase and maintain the insurance coverage as described in this Section for the Contractor in connection with the performance of work by those Subcontractors. Alternatively, Contractor may include any Subcontractors under Contractor's insurance on the coverage required in this Section. Subcontractor(s) must fully comply with the insurance coverage required in this Section. Failure of Subcontractor(s) to comply with insurance requirements does not limit Contractor's liability or responsibility.

2.133 Certificates of Insurance and Other Requirements

Contractor must furnish to DMB-Purchasing Operations, certificate(s) of insurance verifying insurance coverage or providing satisfactory evidence of self-insurance as required in this Section (the "Certificates"). The Certificate must be on the standard "accord" form or equivalent. **THE CONTRACT OR PURCHASE ORDER NO. MUST BE SHOWN ON THE CERTIFICATE OF INSURANCE TO ASSURE CORRECT FILING.** All Certificate(s) are to be prepared and submitted by the Insurance Provider. All Certificate(s) must contain a provision indicating that coverage's afforded under the policies WILL NOT BE CANCELLED, MATERIALLY CHANGED, OR NOT RENEWED without 30 days prior written notice, except for 10 days for non-payment of premium, having been given to the Director of Purchasing Operations, Department of Management and Budget.

The notice must include the Contract or Purchase Order number affected. Before the Contract is signed, and not less than 20 days before the insurance expiration date every year thereafter, the Contractor must provide evidence that the State and its agents, officers and employees are listed as additional insured's under each commercial general liability and commercial automobile liability policy. In the event the State approves the representation of the State by the insurer's attorney, the attorney may be required to be designated as a Special Assistant Attorney General by the Attorney General of the State of Michigan.

The Contractor must maintain all required insurance coverage throughout the term of the Contract and any extensions and, in the case of claims-made Commercial General Liability policies, must secure tail coverage for at least three years following the expiration or termination for any reason of this Contract. The minimum limits of coverage specified above are not intended, and must not be construed, to limit any liability or indemnity of Contractor under this Contract to any indemnified party or other persons. Contractor is responsible for all deductibles with regard to the insurance. If the Contractor fails to pay any premium for required insurance as specified in this Contract, or if any insurer cancels or significantly reduces any required insurance as specified in this Contract without the State's written consent, then the State may, after the State has given the Contractor at least 30 days written notice, pay the premium or procure similar insurance coverage from another company or companies. The State may deduct any part of the cost from any payment due the Contractor, or the Contractor must pay that cost upon demand by the State.

2.140 Indemnification

2.141 General Indemnification

To the extent permitted by law, the Contractor must indemnify, defend and hold harmless the State from liability, including all claims and losses, and all related costs and expenses (including reasonable attorneys' fees and costs of investigation, litigation, settlement, judgments, interest and penalties), accruing or resulting to any person, firm or corporation that may be injured or damaged by the Contractor in the performance of this Contract and that are attributable to the negligence or tortious acts of the Contractor or any of its Subcontractors, or by anyone else for whose acts any of them may be liable.

2.142 Code Indemnification

To the extent permitted by law, the Contractor shall indemnify, defend and hold harmless the State from any claim, loss, or expense arising from Contractor's breach of the No Surreptitious Code Warranty.

2.143 Employee Indemnification

In any claims against the State of Michigan, its departments, divisions, agencies, sections, commissions, officers, employees and agents, by any employee of the Contractor or any of its Subcontractors, the indemnification obligation under the Contract must not be limited in any way by the amount or type of damages, compensation or benefits payable by or for the Contractor or any of its Subcontractors under worker's disability compensation acts, disability benefit acts or other employee benefit acts. This indemnification clause is intended to be comprehensive. Any overlap in provisions, or the fact that greater specificity is provided as to some categories of risk, is not intended to limit the scope of indemnification under any other provisions.

2.144 Patent/Copyright Infringement Indemnification

To the extent permitted by law, the Contractor must indemnify, defend and hold harmless the State from and against all losses, liabilities, damages (including taxes), and all related costs and expenses (including reasonable attorneys' fees and costs of investigation, litigation, settlement, judgments, interest and penalties) incurred in connection with any action or proceeding threatened or brought against the State to the extent that the action or proceeding is based on a claim that any piece of equipment, software, commodity or service supplied by the Contractor or its subcontractors, or the operation of the equipment, software, commodity or service, or the use or reproduction of any documentation provided with the equipment, software, commodity or service infringes any United States patent, copyright, trademark or trade secret of any person or entity, which is enforceable under the laws of the United States.

In addition, should the equipment, software, commodity, or service, or its operation, become or in the State's or Contractor's opinion be likely to become the subject of a claim of infringement, the Contractor must at the Contractor's sole expense (i) procure for the State the right to continue using the equipment, software, commodity or service or, if the option is not reasonably available to the Contractor, (ii) replace or modify to the State's satisfaction the same with equipment, software, commodity or service of equivalent function and performance so that it becomes non-infringing, or, if the option is not reasonably available to Contractor, (iii) accept its return by the State with appropriate credits to the State against the Contractor's charges and reimburse the State for any losses or costs incurred as a consequence of the State ceasing its use and returning it.

Notwithstanding the foregoing, the Contractor has no obligation to indemnify or defend the State for, or to pay any costs, damages or attorneys' fees related to, any claim based upon (i) equipment developed based on written specifications of the State; (ii) use of the equipment in a configuration other than implemented or approved in writing by the Contractor, including, but not limited to, any modification of the equipment by the State; or (iii) the combination, operation, or use of the equipment with equipment or software not supplied by the Contractor under this Contract.

2.145 Continuation of Indemnification Obligations
The Contractor's duty to indemnify under this Section continues in full force and effect, notwithstanding the expiration or early cancellation of the Contract, with respect to any claims based on facts or conditions that occurred before expiration or cancellation.

2.146 Indemnification Procedures
The procedures set forth below must apply to all indemnity obligations under this Contract.

(a) After the State receives notice of the action or proceeding involving a claim for which it will seek indemnification, the State must promptly notify Contractor of the claim in writing and take or assist Contractor in taking, as the case may be, any reasonable action to avoid the imposition of a default judgment against Contractor. No failure to notify the Contractor relieves the Contractor of its indemnification obligations except to the extent that the Contractor can prove damages attributable to the failure. Within 10 days following receipt of written notice from the State relating to any claim, the Contractor must notify the State in writing whether Contractor agrees to assume control of the defense and settlement of that claim (a "Notice of Election"). After notifying Contractor of a claim and before the State receiving Contractor's Notice of Election, the State is entitled to defend against the claim, at the Contractor's expense, and the Contractor will be responsible for any reasonable costs incurred by the State in defending against the claim during that period.

(b) If Contractor delivers a Notice of Election relating to any claim: (i) the State is entitled to participate in the defense of the claim and to employ counsel at its own expense to assist in the handling of the claim and to monitor and advise the State about the status and progress of the defense; (ii) the Contractor must, at the request of the State, demonstrate to the reasonable satisfaction of the State, the Contractor's financial ability to carry out its defense and indemnity obligations under this Contract; (iii) the Contractor must periodically advise the State about the status and progress of the defense and must obtain the prior written approval of the State before entering into any settlement of the claim or ceasing to defend against the claim and (iv) to the extent that any principles of Michigan governmental or public law may be involved or challenged, the State has the right, at its own expense, to control the defense of that portion of the claim involving the principles of Michigan governmental or public law. But the State may retain control of the defense and settlement of a claim by notifying the Contractor in writing within 10 days after the State's receipt of Contractor's information requested by the State under clause (ii) of this paragraph if the State determines that the Contractor has failed to demonstrate to the reasonable satisfaction of the State the Contractor's financial ability to carry out its defense and indemnity obligations under this Section. Any litigation activity on behalf of the State, or any of its subdivisions under this Section, must be coordinated with the Department of Attorney General. In the event the insurer's attorney represents the State under this Section, the insurer's attorney may be required to be designated as a Special Assistant Attorney General by the Attorney General of the State of Michigan.

(c) If Contractor does not deliver a Notice of Election relating to any claim of which it is notified by the State as provided above, the State may defend the claim in the manner as it may deem appropriate, at the cost and expense of Contractor. If it is determined that the claim was one against which Contractor was required to indemnify the State, upon request of the State, Contractor must promptly reimburse the State for all the reasonable costs and expenses.

2.150 Termination/Cancellation

2.151 Notice and Right to Cure
If the Contractor breaches the Contract, and the State in its sole discretion determines that the breach is curable, then the State will provide the Contractor with written notice of the breach and a time period (not less than 30 days) to cure the Breach. The notice of breach and opportunity to cure is inapplicable for successive or repeated breaches or if the State determines in its sole discretion that the breach poses a serious and imminent threat to the health or safety of any person or the imminent loss, damage, or destruction of any real or tangible personal property.

2.152 Termination for Cause

(a) The State may terminate this Contract, for cause, by notifying the Contractor in writing, if the Contractor (i) breaches any of its material duties or obligations under this Contract (including a Chronic Failure to meet any particular SLA), or (ii) fails to cure a breach within the time period specified in the written notice of breach provided by the State

(b) If this Contract is terminated for cause, the Contractor must pay all costs incurred by the State in terminating this Contract, including but not limited to, State administrative costs, reasonable attorneys' fees and court costs, and any reasonable additional costs the State may incur to procure the Services/Deliverables required by this Contract from other sources. Re-procurement costs are not consequential, indirect or incidental damages, and cannot be excluded by any other terms otherwise included in this Contract, provided the costs are not in excess of 50% more than the prices for the Service/Deliverables provided under this Contract.

(c) If the State chooses to partially terminate this Contract for cause, charges payable under this Contract will be equitably adjusted to reflect those Services/Deliverables that are terminated and the State must pay for all Services/Deliverables for which Final Acceptance has been granted provided up to the termination date. Services and related provisions of this Contract that are terminated for cause must cease on the effective date of the termination.

(d) If the State terminates this Contract for cause under this Section, and it is determined, for any reason, that Contractor was not in breach of contract under the provisions of this section, that termination for cause must be deemed to have been a termination for convenience, effective as of the same date, and the rights and obligations of the parties must be limited to that otherwise provided in this Contract for a termination for convenience.

2.153 Termination for Convenience

The State may terminate this Contract for its convenience, in whole or part, if the State determines that a termination is in the State's best interest. Reasons for the termination must be left to the sole discretion of the State and may include, but not necessarily be limited to (a) the State no longer needs the Services or products specified in the Contract, (b) relocation of office, program changes, changes in laws, rules, or regulations make implementation of the Services no longer practical or feasible, (c) unacceptable prices for Additional Services or New Work requested by the State, or (d) falsification or misrepresentation, by inclusion or non-inclusion, of information material to a response to any RFP issued by the State. The State may terminate this Contract for its convenience, in whole or in part, by giving Contractor written notice at least 30 days before the date of termination. If the State chooses to terminate this Contract in part, the charges payable under this Contract must be equitably adjusted to reflect those Services/Deliverables that are terminated. Services and related provisions of this Contract that are terminated for cause must cease on the effective date of the termination.

2.154 Termination for Non-Appropriation

(a) Contractor acknowledges that, if this Contract extends for several fiscal years, continuation of this Contract is subject to appropriation or availability of funds for this Contract. If funds to enable the State to effect continued payment under this Contract are not appropriated or otherwise made available, the State must terminate this Contract and all affected Statements of Work, in whole or in part, at the end of the last period for which funds have been appropriated or otherwise made available by giving written notice of termination to Contractor. The State must give Contractor at least 30 days advance written notice of termination for non-appropriation or unavailability (or the time as is available if the State receives notice of the final decision less than 30 days before the funding cutoff).

(b) If funding for the Contract is reduced by law, or funds to pay Contractor for the agreed-to level of the Services or production of Deliverables to be provided by Contractor are not appropriated or otherwise unavailable, the State may, upon 30 days written notice to Contractor, reduce the level of the Services or the change the production of Deliverables in the manner and for the periods of time as the State may elect. The charges payable under this Contract will be equitably adjusted to reflect any equipment, services or commodities not provided by reason of the reduction.

(c) If the State terminates this Contract, eliminates certain Deliverables, or reduces the level of Services to be provided by Contractor under this Section, the State must pay Contractor for all Work-in-Process performed through the effective date of the termination or reduction in level, as the case may be and as determined by the State, to the extent funds are available. This Section will not preclude Contractor from reducing or stopping Services/Deliverables or raising against the State in a court of competent jurisdiction, any claim for a shortfall in payment for Services performed or Deliverables finally accepted before the effective date of termination.

2.155 Termination for Criminal Conviction
The State may terminate this Contract immediately and without further liability or penalty in the event Contractor, an officer of Contractor, or an owner of a 25% or greater share of Contractor is convicted of a criminal offense related to a State, public or private Contract or subcontract.

2.156 Termination for Approvals Rescinded
The State may terminate this Contract if any final administrative or judicial decision or adjudication disapproves a previously approved request for purchase of personal services under Constitution 1963, Article 11, § 5, and Civil Service Rule 7-1. In that case, the State will pay the Contractor for only the work completed to that point under the Contract. Termination may be in whole or in part and may be immediate as of the date of the written notice to Contractor or may be effective as of the date stated in the written notice.

2.157 Rights and Obligations upon Termination
(a) If the State terminates this Contract for any reason, the Contractor must (a) stop all work as specified in the notice of termination, (b) take any action that may be necessary, or that the State may direct, for preservation and protection of Deliverables or other property derived or resulting from this Contract that may be in Contractor's possession, (c) return all materials and property provided directly or indirectly to Contractor by any entity, agent or employee of the State, (d) transfer title in, and deliver to, the State, unless otherwise directed, all Deliverables intended to be transferred to the State at the termination of the Contract and which are resulting from the Contract (which must be provided to the State on an "As-Is" basis except to the extent the amounts paid by the State in respect of the items included compensation to Contractor for the provision of warranty services in respect of the materials), and (e) take any action to mitigate and limit any potential damages, or requests for Contractor adjustment or termination settlement costs, to the maximum practical extent, including terminating or limiting as otherwise applicable those subcontracts and outstanding orders for material and supplies resulting from the terminated Contract.

(b) If the State terminates this Contract before its expiration for its own convenience, the State must pay Contractor for all charges due for Services provided before the date of termination and, if applicable, as a separate item of payment under this Contract, for Work In Process, on a percentage of completion basis at the level of completion determined by the State. All completed or partially completed Deliverables prepared by Contractor under this Contract, at the option of the State, becomes the State's property, and Contractor is entitled to receive equitable fair compensation for the Deliverables. Regardless of the basis for the termination, the State is not obligated to pay, or otherwise compensate, Contractor for any lost expected future profits, costs or expenses incurred with respect to Services not actually performed for the State.

(c) Upon a good faith termination, the State may assume, at its option, any subcontracts and agreements for services and deliverables provided under this Contract, and may further pursue completion of the Services/Deliverables under this Contract by replacement contract or otherwise as the State may in its sole judgment deem expedient.

2.158 Reservation of Rights
Any termination of this Contract or any Statement of Work issued under it by a party must be with full reservation of, and without prejudice to, any rights or remedies otherwise available to the party with respect to any claims arising before or as a result of the termination.

2.160 Termination by Contractor

2.161 Termination by Contractor
If the State breaches the Contract, and the Contractor in its sole discretion determines that the breach is curable, then the Contractor will provide the State with written notice of the breach and a time period (not less than 30 days) to cure the breach. The Notice of Breach and opportunity to cure is inapplicable for successive and repeated breaches.

The Contractor may terminate this Contract if the State (i) materially breaches its obligation to pay the Contractor undisputed amounts due and owing under this Contract, (ii) breaches its other obligations under this Contract to an extent that makes it impossible or commercially impractical for the Contractor to perform the Services, or (iii) does not cure the breach within the time period specified in a written notice of breach. But the Contractor must discharge its obligations under **Section 2.190** before it terminates the Contract.

2.170 Transition Responsibilities

2.171 Contractor Transition Responsibilities

If the State terminates this Contract, for convenience or cause, or if the Contract is otherwise dissolved, voided, rescinded, nullified, expires or rendered unenforceable, the Contractor agrees to comply with direction provided by the State to assist in the orderly transition of equipment, services, software, leases, etc. to the State or a third party designated by the State. If this Contract expires or terminates, the Contractor agrees to make all reasonable efforts to effect an orderly transition of services within a reasonable period of time that in no event will exceed (60) days. These efforts must include, but are not limited to, those listed in **Sections 2.171, 2.172, 2.173, 2.174, and 2.175.**

2.172 Contractor Personnel Transition

The Contractor must work with the State, or a specified third party, to develop a transition plan setting forth the specific tasks and schedule to be accomplished by the parties, to effect an orderly transition. The Contractor must allow as many personnel as practicable to remain on the job to help the State, or a specified third party, maintain the continuity and consistency of the services required by this Contract. In addition, during or following the transition period, in the event the State requires the Services of the Contractor's subcontractors or vendors, as necessary to meet its needs, Contractor agrees to reasonably, and with good-faith, work with the State to use the Services of Contractor's subcontractors or vendors. Contractor will notify all of Contractor's subcontractors of procedures to be followed during transition.

2.173 Contractor Information Transition

The Contractor agrees to provide reasonable detailed specifications for all Services/Deliverables needed by the State, or specified third party, to properly provide the Services/Deliverables required under this Contract. The Contractor will provide the State with asset management data generated from the inception of this Contract through the date on which this Contractor is terminated in a comma-delineated format unless otherwise requested by the State. The Contractor will deliver to the State any remaining owed reports and documentation still in Contractor's possession subject to appropriate payment by the State.

2.174 Contractor Software Transition

The Contractor must reasonably assist the State in the acquisition of any Contractor software required to perform the Services/use the Deliverables under this Contract. This must include any documentation being used by the Contractor to perform the Services under this Contract. If the State transfers any software licenses to the Contractor, those licenses must, upon expiration of the Contract, transfer back to the State at their current revision level. Upon notification by the State, Contractor may be required to freeze all non-critical changes to Deliverables/Services.

2.175 Transition Payments

If the transition results from a termination for any reason, reimbursement must be governed by the termination provisions of this Contract. If the transition results from expiration, the Contractor will be reimbursed for all reasonable transition costs (i.e. costs incurred within the agreed period after contract expiration that result from transition operations) at the rates agreed upon by the State. The Contractor will prepare an accurate accounting from which the State and Contractor may reconcile all outstanding accounts.

2.176 State Transition Responsibilities

In the event that this Contract is terminated, dissolved, voided, rescinded, nullified, or otherwise rendered unenforceable, the State agrees to perform the following obligations, and any others upon which the State and the Contractor agree:

(a) Reconciling all accounts between the State and the Contractor;
(b) Completing any pending post-project reviews.

2.180 Stop Work

2.181 Stop Work Orders

The State may, at any time, by written stop work order to Contractor, require that Contractor stop all, or any part, of the work called for by the Contract for a period of up to 90 calendar days after the stop work order is delivered to Contractor, and for any further period to which the parties may agree. The stop work order must be identified as a stop work order and must indicate that it is issued under this **Section 2.180**. Upon receipt of the stop work order, Contractor must immediately comply with its terms and take all reasonable steps to minimize incurring costs allocable to the work covered by the stop work order during the period of work stoppage. Within the period of the stop work order, the State must either: (a) cancel the stop work order; or (b) terminate the work covered by the stop work order as provided in **Section 2.150**.

2.182 Cancellation or Expiration of Stop Work Order

The Contractor must resume work if the State cancels a Stop Work Order or if it expires. The parties will agree upon an equitable adjustment in the delivery schedule, the Contract price, or both, and the Contract must be modified, in writing, accordingly, if: (a) the stop work order results in an increase in the time required for, or in Contractor's costs properly allocable to, the performance of any part of the Contract; and (b) Contractor asserts its right to an equitable adjustment within 30 calendar days after the end of the period of work stoppage; provided that, if the State decides the facts justify the action, the State may receive and act upon a Contractor proposal submitted at any time before final payment under the Contract. Any adjustment will conform to the requirements of **Section 2.024**.

2.183 Allowance of Contractor Costs

If the stop work order is not canceled and the work covered by the stop work order is terminated for reasons other than material breach, the termination must be deemed to be a termination for convenience under **Section 2.150**, and the State will pay reasonable costs resulting from the stop work order in arriving at the termination settlement. For the avoidance of doubt, the State is not to be liable to Contractor for loss of profits because of a stop work order issued under this **Section 2.180.**

2.190 Dispute Resolution

2.191 In General

Any claim, counterclaim, or dispute between the State and Contractor arising out of or relating to the Contract or any Statement of Work must be resolved as follows. For all Contractor claims seeking an increase in the amounts payable to Contractor under the Contract, or the time for Contractor's performance, Contractor must submit a letter, together with all data supporting the claims, executed by Contractor's Contract Administrator or the Contract Administrator's designee certifying that (a) the claim is made in good faith, (b) the amount claimed accurately reflects the adjustments in the amounts payable to Contractor or the time for Contractor's performance for which Contractor believes the State is liable and covers all costs of every type to which Contractor is entitled from the occurrence of the claimed event, and (c) the claim and the supporting data are current and complete to Contractor's best knowledge and belief.

2.192 Informal Dispute Resolution

(a) All disputes between the parties must be resolved under the Contract Management procedures in this Contract. If the parties are unable to resolve any disputes after compliance with the processes, the parties must meet with the Director of Purchasing Operations, DMB, or designee, for the purpose of attempting to resolve the dispute without the need for formal legal proceedings, as follows:

(i) The representatives of Contractor and the State must meet as often as the parties reasonably deem necessary to gather and furnish to each other all information with respect to the matter in issue which the parties believe to be appropriate and germane in connection with its resolution. The representatives must discuss the problem and negotiate in good faith in an effort to resolve the dispute without the necessity of any formal proceeding.

(ii) During the course of negotiations, all reasonable requests made by one party to another for non-privileged information reasonably related to the Contract will be honored in order that each of the parties may be fully advised of the other's position.

(iii) The specific format for the discussions will be left to the discretion of the designated State and Contractor representatives, but may include the preparation of agreed upon statements of fact or written statements of position.

(iv) Following the completion of this process within 60 calendar days, the Director of Purchasing Operations, DMB, or designee, must issue a written opinion regarding the issue(s) in dispute within 30 calendar days. The opinion regarding the dispute must be considered the State's final action and the exhaustion of administrative remedies.

(b) This Section will not be construed to prevent either party from instituting, and a party is authorized to institute, formal proceedings earlier to avoid the expiration of any applicable limitations period, to preserve a superior position with respect to other creditors, or under **Section 2.193**.

(c) The State will not mediate disputes between the Contractor and any other entity, except state agencies, concerning responsibility for performance of work under the Contract.

2.193 Injunctive Relief
The only circumstance in which disputes between the State and Contractor will not be subject to the provisions of **Section 2.192** is where a party makes a good faith determination that a breach of the terms of the Contract by the other party is the that the damages to the party resulting from the breach will be so immediate, so large or severe and so incapable of adequate redress after the fact that a temporary restraining order or other immediate injunctive relief is the only adequate remedy.

2.194 Continued Performance
Each party agrees to continue performing its obligations under the Contract while a dispute is being resolved except to the extent the issue in dispute precludes performance (dispute over payment must not be deemed to preclude performance) and without limiting either party's right to terminate the Contract as provided in **Section 2.150**, as the case may be.

2.200 Federal and State Contract Requirements

2.201 Nondiscrimination
In the performance of the Contract, Contractor agrees not to discriminate against any employee or applicant for employment, with respect to his or her hire, tenure, terms, conditions or privileges of employment, or any matter directly or indirectly related to employment, because of race, color, religion, national origin, ancestry, age, sex, height, weight, marital status, physical or mental disability. Contractor further agrees that every subcontract entered into for the performance of this Contract or any purchase order resulting from this Contract will contain a provision requiring non-discrimination in employment, as specified here, binding upon each Subcontractor. This covenant is required under the Elliot Larsen Civil Rights Act, 1976 PA 453, MCL 37.2101, et seq., and the Persons with Disabilities Civil Rights Act, 1976 PA 220, MCL 37.1101, et seq., and any breach of this provision may be regarded as a material breach of the Contract.

2.202 Unfair Labor Practices
Under 1980 PA 278, MCL 423.321, et seq., the State must not award a Contract or subcontract to an employer whose name appears in the current register of employers failing to correct an unfair labor practice compiled under Section 2 of the Act. This information is compiled by the United States National Labor Relations Board. A Contractor of the State, in relation to the Contract, must not enter into a contract with a Subcontractor, manufacturer, or supplier whose name appears in this register. Under Section 4 of 1980 PA 278, MCL 423.324, the State may void any Contract if, after award of the Contract, the name of Contractor as an employer or the name of the Subcontractor, manufacturer or supplier of Contractor appears in the register.

2.203 Workplace Safety and Discriminatory Harassment
In performing Services for the State, the Contractor must comply with the Department of Civil Services Rule 2-20 regarding Workplace Safety and Rule 1-8.3 regarding Discriminatory Harassment. In addition, the Contractor must comply with Civil Service regulations and any applicable agency rules provided to the Contractor. For Civil Service Rules, see http://www.mi.gov/mdcs/0,1607,7-147-6877---,00.html.

2.204 Prevailing Wage – Deleted – Not Applicable

2.210 Governing Law

2.211 Governing Law
The Contract must in all respects be governed by, and construed according to, the substantive laws of the State of Michigan without regard to any Michigan choice of law rules that would apply the substantive law of any other jurisdiction to the extent not inconsistent with, or pre-empted by federal law.

2.212 Compliance with Laws
Contractor shall comply with all applicable state, federal and local laws and ordinances in providing the Services/Deliverables.

2.213 Jurisdiction

Any dispute arising from the Contract must be resolved in the State of Michigan. With respect to any claim between the parties, Contractor consents to venue in Ingham County, Michigan, and irrevocably waives any objections it may have to the jurisdiction on the grounds of lack of personal jurisdiction of the court or the laying of venue of the court or on the basis of forum non conveniens or otherwise. Contractor agrees to appoint agents in the State of Michigan to receive service of process.

2.220 Limitation of Liability

2.221 Limitation of Liability

Neither the Contractor nor the State is liable to each other, regardless of the form of action, for consequential, incidental, indirect, or special damages. This limitation of liability does not apply to claims for infringement of United States patent, copyright, trademark or trade secrets; to claims for personal injury or damage to property caused by the gross negligence or willful misconduct of the Contractor; to claims covered by other specific provisions of this Contract calling for liquidated damages; or to court costs or attorney's fees awarded by a court in addition to damages after litigation based on this Contract.

2.230 Disclosure Responsibilities

2.231 Disclosure of Litigation

(a) Disclosure. Contractor must disclose any material criminal litigation, investigations or proceedings involving the Contractor (and each Subcontractor) or any of its officers or directors or any litigation, investigations or proceedings under the Sarbanes-Oxley Act. In addition, each Contractor (and each Subcontractor) must notify the State of any material civil litigation, arbitration or proceeding which arises during the term of the Contract and extensions, to which Contractor (or, to the extent Contractor is aware, any Subcontractor) is a party, and which involves: (i) disputes that might reasonably be expected to adversely affect the viability or financial stability of Contractor or any Subcontractor; or (ii) a claim or written allegation of fraud against Contractor or, to the extent Contractor is aware, any Subcontractor by a governmental or public entity arising out of their business dealings with governmental or public entities. The Contractor must disclose in writing to the Contract Administrator any litigation, investigation, arbitration or other proceeding (collectively, "Proceeding") within 30 days of its occurrence. Details of settlements which are prevented from disclosure by the terms of the settlement may be annotated. Information provided to the State from Contractor's publicly filed documents referencing its material litigation will be deemed to satisfy the requirements of this Section.

(b) Assurances. If any Proceeding disclosed to the State under this Section, or of which the State otherwise becomes aware, during the term of this Contract would cause a reasonable party to be concerned about:

(i) The ability of Contractor (or a Subcontractor) to continue to perform this Contract according to its terms and conditions, or

(ii) whether Contractor (or a Subcontractor) in performing Services for the State is engaged in conduct which is similar in nature to conduct alleged in the Proceeding, which conduct would constitute a breach of this Contract or a violation of Michigan law, regulations or public policy, then the Contractor must provide the State all reasonable assurances requested by the State to demonstrate that:

(a) Contractor and its Subcontractors will be able to continue to perform this Contract and any Statements of Work according to its terms and conditions, and

(b) Contractor and its Subcontractors have not and will not engage in conduct in performing the Services which is similar in nature to the conduct alleged in the Proceeding.

(c) Contractor must make the following notifications in writing:

(1) Within 30 days of Contractor becoming aware that a change in its ownership or officers has occurred, or is certain to occur, or a change that could result in changes in the valuation of its capitalized assets in the accounting records, Contractor must notify DMB Purchasing Operations.

(2) Contractor must also notify DMB Purchasing Operations within 30 days whenever changes to asset valuations or any other cost changes have occurred or are certain to occur as a result of a change in ownership or officers.

(3) Contractor must also notify DMB Purchasing Operations within 30 days whenever changes to company affiliations occur.

2.232 Call Center Disclosure– Deleted – Not Applicable

2.233 Bankruptcy

The State may, without prejudice to any other right or remedy, terminate this Contract, in whole or in part, and, at its option, may take possession of the "Work in Process" and finish the Works in Process by whatever appropriate method the State may deem expedient if:

(a) The Contractor files for protection under the bankruptcy laws;
(b) An involuntary petition is filed against the Contractor and not removed within 30 days;
(c) The Contractor becomes insolvent or if a receiver is appointed due to the Contractor's insolvency;
(d) The Contractor makes a general assignment for the benefit of creditors; or
(e) The Contractor or its affiliates are unable to provide reasonable assurances that the Contractor or its affiliates can deliver the services under this Contract.

Contractor will fix appropriate notices or labels on the Work in Process to indicate ownership by the State. To the extent reasonably possible, materials and Work in Process must be stored separately from other stock and marked conspicuously with labels indicating ownership by the State.

2.240 Performance

2.241 Time of Performance

(a) Contractor must use commercially reasonable efforts to provide the resources necessary to complete all Services and Deliverables according to the time schedules contained in the Statements of Work and other Exhibits governing the work, and with professional quality.

(b) Without limiting the generality of **Section 2.241(a),** Contractor must notify the State in a timely manner upon becoming aware of any circumstances that may reasonably be expected to jeopardize the timely and successful completion of any Deliverables/Services on the scheduled due dates in the latest State-approved delivery schedule and must inform the State of the projected actual delivery date.

(c) If the Contractor believes that a delay in performance by the State has caused or will cause the Contractor to be unable to perform its obligations according to specified Contract time periods, the Contractor must notify the State in a timely manner and must use commercially reasonable efforts to perform its obligations according to the Contract time periods notwithstanding the State's failure. Contractor will not be in default for a delay in performance to the extent the delay is caused by the State.

2.242 Service Level Agreements (SLAs)- Deleted – Not Applicable

2.243 Liquidated Damages- Deleted – Not Applicable

2.244 Excusable Failure

Neither party will be liable for any default, damage or delay in the performance of its obligations under the Contract to the extent the default, damage or delay is caused by government regulations or requirements (executive, legislative, judicial, military or otherwise), power failure, electrical surges or current fluctuations, lightning, earthquake, war, water or other forces of nature or acts of God, delays or failures of transportation, equipment shortages, suppliers' failures, or acts or omissions of common carriers, fire; riots, civil disorders; strikes or other labor disputes, embargoes; injunctions (provided the injunction was not issued as a result of any fault or negligence of the party seeking to have its default or delay excused); or any other cause beyond the reasonable control of a party; provided the non-performing party and its Subcontractors are without fault in causing the default or delay, and the default or delay could not have been prevented by reasonable precautions and cannot reasonably be circumvented by the non-performing party through the use of alternate sources, workaround plans or other means, including disaster recovery plans.

If a party does not perform its contractual obligations for any of the reasons listed above, the non-performing party will be excused from any further performance of its affected obligation(s) for as long as the circumstances prevail. But the party must use commercially reasonable efforts to recommence performance whenever and to whatever extent possible without delay. A party must promptly notify the other party in writing immediately after the excusable failure occurs, and also when it abates or ends.

If any of the above-enumerated circumstances substantially prevent, hinder, or delay the Contractor's performance of the Services/provision of Deliverables for more than 10 Business Days, and the State determines that performance is not likely to be resumed within a period of time that is satisfactory to the State in its reasonable discretion, then at the State's option: (a) the State may procure the affected Services/Deliverables from an alternate source, and the State is not be liable for payment for the unperformed Services/ Deliverables not provided under the Contract for so long as the delay in performance continues; (b) the State may terminate any portion of the Contract so affected and the charges payable will be equitably adjusted to reflect those Services/Deliverables terminated; or (c) the State may terminate the affected Statement of Work without liability to Contractor as of a date specified by the State in a written notice of termination to the Contractor, except to the extent that the State must pay for Services/Deliverables provided through the date of termination.

The Contractor will not have the right to any additional payments from the State as a result of any Excusable Failure occurrence or to payments for Services not rendered/Deliverables not provided as a result of the Excusable Failure condition. Defaults or delays in performance by Contractor which are caused by acts or omissions of its Subcontractors will not relieve Contractor of its obligations under the Contract except to the extent that a Subcontractor is itself subject to an Excusable Failure condition described above and Contractor cannot reasonably circumvent the effect of the Subcontractor's default or delay in performance through the use of alternate sources, workaround plans or other means.

2.250 Approval of Deliverables

2.251 Delivery Responsibilities – Deleted – Not Applicable

2.252 Delivery of Deliverables

Where applicable, the Statements of Work/POs contain lists of the Deliverables to be prepared and delivered by Contractor including, for each Deliverable, the scheduled delivery date and a designation of whether the Deliverable is a document ("Written Deliverable"), a good ("Physical Deliverable") or a Service. All Deliverables must be completed and delivered for State review and written approval and, where applicable, installed according to the State-approved delivery schedule and any other applicable terms and conditions of the Contract.

2.253 Testing – Deleted – Not Applicable

2.254 Approval of Deliverables, In General

(a) All Deliverables (Physical Deliverables and Written Deliverables) and Services require formal written approval by the State, according to the following procedures. Formal approval by the State requires the State to confirm in writing that the Deliverable meets its specifications. The approval process will be facilitated by ongoing consultation between the parties, inspection of interim and intermediate Deliverables and collaboration on key decisions.

(b) The State's obligation to comply with any State Review Period is conditioned on the timely delivery of Deliverables/Services being reviewed.

(c) Before commencement of its review or testing of a Deliverable/Service, the State may inspect the Deliverable/Service to confirm that all components of the Deliverable/Service have been delivered without material deficiencies. If the State determines that the Deliverable/Service has material deficiencies, the State may refuse delivery of the Deliverable/Service without performing any further inspection or testing of the Deliverable/Service. Otherwise, the review period will be deemed to have started on the day the State receives the Deliverable or the Service begins, and the State and Contractor agree that the Deliverable/Service is ready for use.

(d) The State will approve in writing a Deliverable/Service after confirming that it conforms to and performs according to its specifications without material deficiency. The State may, but is not be required to, conditionally approve in writing a Deliverable/Service that contains material deficiencies if the State elects to permit Contractor to rectify them post-approval. In any case, Contractor will be responsible for working diligently to correct within a reasonable time at Contractor's expense all deficiencies in the Deliverable/Service that remain outstanding at the time of State approval.

(e) If, after three opportunities (the original and two repeat efforts), the Contractor is unable to correct all deficiencies preventing Final Acceptance of a Deliverable/Service, the State may: (i) demand that the Contractor cure the failure and give the Contractor additional time to cure the failure at the sole expense of the Contractor; or (ii) keep the Contract in force and do, either itself or through other parties, whatever the Contractor has failed to do, and recover the difference between the cost to cure the deficiency and the contract price plus an additional sum equal to 10% of the cost to cure the deficiency to cover the State's general expenses provided the State can furnish proof of the general expenses; or (iii) terminate the particular Statement of Work for default, either in whole or in part by notice to Contractor provided Contractor is unable to cure the breach. Notwithstanding the foregoing, the State cannot use, as a basis for exercising its termination rights under this Section, deficiencies discovered in a repeat State Review Period that could reasonably have been discovered during a prior State Review Period.

(f) The State, at any time and in its reasonable discretion, may halt the testing or approval process if the process reveals deficiencies in or problems with a Deliverable/Service in a sufficient quantity or of a sufficient severity that renders continuing the process unproductive or unworkable. If that happens, the State may stop using the Service or return the applicable Deliverable to Contractor for correction and re-delivery before resuming the testing or approval process.

2.255 Process for Approval of Written Deliverables

The State Review Period for Written Deliverables will be the number of days set forth in the applicable Statement of Work following delivery of the final version of the Deliverable (and if the Statement of Work does not state the State Review Period, it is by default five Business Days for Written Deliverables of 100 pages or less and 10 Business Days for Written Deliverables of more than 100 pages). The duration of the State Review Periods will be doubled if the State has not had an opportunity to review an interim draft of the Written Deliverable before its submission to the State. The State agrees to notify Contractor in writing by the end of the State Review Period either stating that the Deliverable is approved in the form delivered by Contractor or describing any deficiencies that must be corrected before approval of the Deliverable (or at the State's election, after approval of the Deliverable). If the State notifies the Contractor about deficiencies, the Contractor will correct the described deficiencies and within 30 Business Days resubmit the Deliverable in a form that shows all revisions made to the original version delivered to the State. Contractor's correction efforts will be made at no additional charge. Upon receipt of a corrected Deliverable from Contractor, the State will have a reasonable additional period of time, not to exceed the length of the original State Review Period, to review the corrected Deliverable to confirm that the identified deficiencies have been corrected.

2.256 Process for Approval of Services

The State Review Period for approval of Services is governed by the applicable Statement of Work (and if the Statement of Work does not state the State Review Period, it is by default 30 Business Days for Services). The State agrees to notify the Contractor in writing by the end of the State Review Period either stating that the Service is approved in the form delivered by the Contractor or describing any deficiencies that must be corrected before approval of the Services (or at the State's election, after approval of the Service). If the State delivers to the Contractor a notice of deficiencies, the Contractor will correct the described deficiencies and within 30 Business Days resubmit the Service in a form that shows all revisions made to the original version delivered to the State. The Contractor's correction efforts will be made at no additional charge. Upon implementation of a corrected Service from Contractor, the State will have a reasonable additional period of time, not to exceed the length of the original State Review Period, to review the corrected Service for conformity and that the identified deficiencies have been corrected.

2.257 Process for Approval of Physical Deliverables – Deleted – Not Applicable

2.258 Final Acceptance

Unless otherwise stated in the Article 1, Statement of Work or Purchase Order, "Final Acceptance" of each Deliverable must occur when each Deliverable/Service has been approved by the State following the State Review Periods identified in **Sections 2.251-2.257**. Payment will be made for Deliverables installed and accepted. Upon acceptance of a Service, the State will pay for all Services provided during the State Review Period that conformed to the acceptance criteria.

2.260 Ownership

2.261 Ownership of Work Product by State

The State owns all Deliverables as they are works made for hire by the Contractor for the State. The State owns all United States and international copyrights, trademarks, patents or other proprietary rights in the Deliverables.

2.262 Vesting of Rights
With the sole exception of any preexisting licensed works identified in the SOW, the Contractor assigns, and upon creation of each Deliverable automatically assigns, to the State, ownership of all United States and international copyrights, trademarks, patents, or other proprietary rights in each and every Deliverable, whether or not registered by the Contractor, insofar as any the Deliverable, by operation of law, may not be considered work made for hire by the Contractor for the State. From time to time upon the State's request, the Contractor must confirm the assignment by execution and delivery of the assignments, confirmations of assignment, or other written instruments as the State may request. The State may obtain and hold in its own name all copyright, trademark, and patent registrations and other evidence of rights that may be available for Deliverables.

2.263 Rights in Data
(a) The State is the owner of all data made available by the State to the Contractor or its agents, Subcontractors or representatives under the Contract. The Contractor will not use the State's data for any purpose other than providing the Services, nor will any part of the State's data be disclosed, sold, assigned, leased or otherwise disposed of to the general public or to specific third parties or commercially exploited by or on behalf of the Contractor. No employees of the Contractor, other than those on a strictly need-to-know basis, have access to the State's data. Contractor will not possess or assert any lien or other right against the State's data. Without limiting the generality of this Section, the Contractor must only use personally identifiable information as strictly necessary to provide the Services and must disclose the information only to its employees who have a strict need-to-know the information. The Contractor must comply at all times with all laws and regulations applicable to the personally identifiable information.

(b) The State is the owner of all State-specific data under the Contract. The State may use the data provided by the Contractor for any purpose. The State will not possess or assert any lien or other right against the Contractor's data. Without limiting the generality of this Section, the State may use personally identifiable information only as strictly necessary to utilize the Services and must disclose the information only to its employees who have a strict need to know the information, except as provided by law. The State must comply at all times with all laws and regulations applicable to the personally identifiable information. Other material developed and provided to the State remains the State's sole and exclusive property.

2.264 Ownership of Materials
The State and the Contractor will continue to own their respective proprietary technologies developed before entering into the Contract. Any hardware bought through the Contractor by the State, and paid for by the State, will be owned by the State. Any software licensed through the Contractor and sold to the State, will be licensed directly to the State.

2.270 State Standards

2.271 Existing Technology Standards
The Contractor will adhere to all existing standards as described within the comprehensive listing of the State's existing technology standards at http://www.michigan.gov/dit.

2.272 Acceptable Use Policy
To the extent that Contractor has access to the State computer system, Contractor must comply with the State's Acceptable Use Policy, see http://www.michigan.gov/ditservice. All Contractor employees must be required, in writing, to agree to the State's Acceptable Use Policy before accessing the State system. The State reserves the right to terminate Contractor's access to the State system if a violation occurs.

2.273 Systems Changes
Contractor is not responsible for and not authorized to make changes to any State systems without written authorization from the Project Manager. Any changes Contractor makes to State systems with the State's approval must be done according to applicable State procedures, including security, access and configuration management procedures.

2.280 Extended Purchasing – Deleted – Not Applicable

2.290 Environmental Provision

2.291 Environmental Provision

Energy Efficiency Purchasing Policy – The State seeks wherever possible to purchase energy efficient products. This includes giving preference to U.S. Environmental Protection Agency (EPA) certified 'Energy Star' products for any category of products for which EPA has established Energy Star certification. For other purchases, the State may include energy efficiency as one of the priority factors to consider when choosing among comparable products.

Environmental Purchasing Policy – The State of Michigan is committed to encouraging the use of products and services that impact the environment less than competing products. The State is accomplishing this by including environmental considerations in purchasing decisions, while remaining fiscally responsible, to promote practices that improve worker health, conserve natural resources, and prevent pollution. Environmental components that are to be considered include: recycled content and recyclability; energy efficiency; and the presence of undesirable materials in the products, especially those toxic chemicals which are persistent and bioaccumulative. The Contractor should be able to supply products containing recycled and environmentally preferable materials that meet performance requirements and is encouraged to offer such products throughout the duration of this Contract. Information on any relevant third party certification (such as Green Seal, Energy Star, etc.) should also be provided.

Hazardous Materials:
For the purposes of this Section, "Hazardous Materials" is a generic term used to describe asbestos, ACBMs, PCBs, petroleum products, construction materials including paint thinners, solvents, gasoline, oil, and any other material the manufacture, use, treatment, storage, transportation or disposal of which is regulated by the federal, state or local laws governing the protection of the public health, natural resources or the environment. This includes, but is not limited to, materials the as batteries and circuit packs, and other materials that are regulated as (1) "Hazardous Materials" under the Hazardous Materials Transportation Act, (2) "chemical hazards" under the Occupational Safety and Health Administration standards, (3) "chemical substances or mixtures" under the Toxic Substances Control Act, (4) "pesticides" under the Federal Insecticide Fungicide and Rodenticide Act, and (5) "hazardous wastes" as defined or listed under the Resource Conservation and Recovery Act.

(a) The Contractor must use, handle, store, dispose of, process, transport and transfer any material considered a Hazardous Material according to all federal, State and local laws. The State must provide a safe and suitable environment for performance of Contractor's Work. Before the commencement of Work, the State must advise the Contractor of the presence at the work site of any Hazardous Material to the extent that the State is aware of the Hazardous Material. If the Contractor encounters material reasonably believed to be a Hazardous Material and which may present a substantial danger, the Contractor must immediately stop all affected Work, notify the State in writing about the conditions encountered, and take appropriate health and safety precautions.

(b) Upon receipt of a written notice, the State will investigate the conditions. If (a) the material is a Hazardous Material that may present a substantial danger, and (b) the Hazardous Material was not brought to the site by the Contractor, or does not result in whole or in part from any violation by the Contractor of any laws covering the use, handling, storage, disposal of, processing, transport and transfer of Hazardous Materials, the State must order a suspension of Work in writing. The State must proceed to have the Hazardous Material removed or rendered harmless. In the alternative, the State must terminate the affected Work for the State's convenience.

(c) Once the Hazardous Material has been removed or rendered harmless by the State, the Contractor must resume Work as directed in writing by the State. Any determination by the Michigan Department of Community Health or the Michigan Department of Environmental Quality that the Hazardous Material has either been removed or rendered harmless is binding upon the State and Contractor for the purposes of resuming the Work. If any incident with Hazardous Material results in delay not reasonable anticipatable under the circumstances and which is attributable to the State, the applicable SLAs for the affected Work will not be counted in **Section 2.242** for a time as mutually agreed by the parties.

(d) If the Hazardous Material was brought to the site by the Contractor, or results in whole or in part from any violation by the Contractor of any laws covering the use, handling, storage, disposal of, processing, transport and transfer of Hazardous Material, or from any other act or omission within the control of the Contractor, the Contractor must bear its proportionate share of the delay and costs involved in cleaning up the site and removing and rendering harmless the Hazardous Material according to Applicable Laws to the condition approved by applicable regulatory agency(ies).

Michigan has a Consumer Products Rule pertaining to labeling of certain products containing volatile organic compounds. For specific details visit http://www.michigan.gov/deq/0,1607,7-135-3310_4108-173523--,00.html

Refrigeration and Air Conditioning:
The Contractor shall comply with the applicable requirements of Sections 608 and 609 of the Clean Air Act (42 U.S.C. 7671g and 7671h) as each or both apply to this Contract.

Environmental Performance:
Waste Reduction Program - Contractor shall establish a program to promote cost-effective waste reduction in all operations and facilities covered by this Contract. The Contractor's programs shall comply with applicable Federal, State, and local requirements, specifically including Section 6002 of the Resource Conservation and Recovery Act (42 U.S.C. 6962, et seq.).

2.300 Other Provisions – Deleted – Not Applicable

Attachment A, Price Proposal

The Contractor is offering to the State 2% discount off invoice if paid within 30 days.

The first listed time period denotes the State Fiscal Year(s) under audit. The time period below the State Fiscal Year(s) denotes the contract year.

	SFY 2005 & 2006	SFY 2007	SFY 2008	SFY 2009	SFY 2010	SFY 2011
Description	**9/1/09 - 9/30/09**	**10/1/09 – 9/30/10**	**10/1/10 – 9/30/11**	**10/1/11 - 9/30/12**	**10/1/12 - 9/30/13**	**10/1/13 – 9/30/14**
Consulting Fees	**$542,160.00**	**$271,080.00**	**$276,500.00**	**$276,500.00**	**$282,000.00**	**$282,000.00**
Include all services specified in the Work and Deliverables Section 1.022.	**$5,420.00**	**$2,710.00**	**$2,765.00**	**$2,765.00**	**$2,820.00**	**$2,820.00**
Administrative Costs (specify)	**1**	**1**	**1**	**1**	**1**	**1**
Include number of required staff and position descriptions of each.						
Miscellaneous (specify)						
Travel (if not included in consulting fee)	**$990.00**	**$990.00**	**$990.00**	**$990.00**	**$990.00**	**$990.00**
Grand Totals	**$548,570.00**	**$274,780.00**	**$280,255.00**	**$280,255.00**	**$285,810..00**	**$285,810.00**

Attachment B, Final Rule Abridged

[Federal Register: December 19, 2008 (Volume 73, Number 245)][Rules and Regulations

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Part III

Department of Health and Human Services

Centers for Medicare & Medicaid Services
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42 CFR Parts 447 and 455

Medicaid Program; Disproportionate Share Hospital Payments; Final Rule

[[Page 77904]]

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
42 CFR Parts 447 and 455
[CMS-2198-F]
RIN 0938-AN09

Medicaid Program; Disproportionate Share Hospital Payments
AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.
ACTION: Final rule.

SUMMARY: This final rule sets forth the data elements necessary to comply with the requirements of Section 1923(j) of the Social Security Act (Act) related to auditing and reporting of disproportionate share hospital payments under State Medicaid programs. These requirements were added by Section 1001(d) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).

DATES: Effective Date: This rule is effective on January 19, 2009.

FOR FURTHER INFORMATION CONTACT: Venesa Day, (410) 786-8281; Rory Howe, (410) 786-4878; and Rob Weaver, (410) 786-5914.

SUPPLEMENTARY INFORMATION:

I. Background

Title XIX of the Social Security Act (Act) authorizes Federal grants to States for Medicaid programs that provide medical assistance to low-income families, the elderly and persons with disabilities. Section 1902(a)(13)(A)(iv) of the Act requires that States make Medicaid payment adjustments for hospitals that serve a disproportionate share of low-income patients with special needs.

Section 1923 of the Act contains more specific requirements related to such disproportionate share hospital (DSH) payments, including aggregate annual state-specific limits on Federal financial participation under Section 1923(f), and hospital-specific limits on DSH payments under Section 1923(g). Under those hospital specific limits, a hospital's DSH payments may not exceed the costs incurred by that hospital in furnishing services during the year to Medicaid patients and the uninsured, less other Medicaid payments made to the hospital, and payments made by uninsured patients (``uncompensated care costs''). In addition, Section 1923(a)(2)(D) requires States to provide an annual report to the Secretary describing the payment adjustments made to each disproportionate share hospital.

Section 1001(d) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108-173, enacted on December 8, 2003) added Section 1923(j) to the Act to require States to report additional information about their DSH programs. Section 1923(j)(1) of the Act requires States to submit an annual report that includes the following:

Identification of each DSH facility that received a DSH payment under the State's Medicaid program in the preceding fiscal year and the amount of DSH payments paid to that hospital in the same year.

Such other information as the Secretary of Health and Human Services determines necessary to ensure the appropriateness of DSH payments.

Section 1923(j)(2) of the Act also requires States to have their DSH payment programs independently audited and to submit the independent certified audit annually to the Secretary. The certified independent audit must verify:

The extent to which hospitals in the State have reduced uncompensated care costs to reflect the total amount of claimed expenditures made under Section 1923 of the Act.

DSH payments to each hospital comply with the applicable hospital-specific DSH payment limit.

Only the uncompensated care costs of providing inpatient hospital and outpatient hospital services to Medicaid eligible individuals and uninsured individuals as described in Section 1923(g)(1)(A) of the Act are included in the calculation of the hospital-specific limits.

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

The State has separately documented and retained a record of all its costs under the Medicaid program, claimed expenditures under the Medicaid program, uninsured costs in determining payment adjustments under Section 1923 of the Act, and any payments made on behalf of the uninsured from payment adjustments under Section 1923 of the Act.

In addition to these reporting requirements, under Section 1923(j) of the Act, Federal matching payments are contingent upon a State's submission of the annual DSH report and independent certified audit.

II. Summary of the Proposed Regulations

On August 26, 2005, we published in the Federal Register (70 FR 50262-50268) a notice of proposed rulemaking implementing the reporting and auditing requirements for State Disproportionate Share Hospital payments. In this notice of proposed rulemaking, we proposed modifying the DSH reporting requirements in Federal regulations at 42 CFR 447 by providing the following changes to our regulations:

1. Reporting Requirements

To implement the reporting requirements in Section 1923(j)(1) of the Act, we proposed to modify the DSH reporting requirements in Federal regulations at 42 CFR 447.

We proposed to add a new paragraph (c) to the reporting requirements in Sec. 447.299.

We proposed to redesignate the documentation requirements in paragraph (c) as paragraph (d) and redesignate the deferrals and disallowances information in paragraph (d) as paragraph (e), respectively.

We proposed a list of information to reflect the data elements necessary to ensure that DSH payments are appropriate such that each qualifying hospital receives no more in DSH payments than the amount permitted under Section 1923(g) of the act.

We proposed that paragraph (c) would require each State receiving an allotment under Section 1923(f) of the Act, beginning with the first full State fiscal year (SFY) immediately after the enactment of Section 1001(d) of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) and each year thereafter, to report to us the list of information detailed in an Reporting form, which was published in the September 23, 2005 correction notice entitled ``Medicaid Programs; Disproportionate Share Hospital Payments''.

We proposed that States will need to consider a Section 1011 payment when determining the hospital's DSH limit, because the total DSH payments should not exceed the total amount of uncompensated care at the hospital.

The information supplied on this spreadsheet would satisfy the requirements under Sections 1923(a)(2)(D) and 1923(j)(1) of the Act.

2. Audit Requirements

We explained the statute's requirement for States to verify their methodology for computing the hospital specific DSH limit and the DSH payments made to hospitals. As required by Section 1923(j)(2) of the Act, these five items identified in statute would provide independent verification that State Medicaid DSH payments comply with the hospital-specific DSH limit in Section 1923(g) of the Act, and that such limits are accurately computed.

In Sec. 455.201, we proposed that ``SFY'' stands for State fiscal year.

We proposed to define that an ``independent audit'' means an audit conducted according to the standards specified in the generally accepted government auditing standards issued by the Comptroller General of the United States.

We proposed adding a new Sec. 455.204(a) to reflect Section 1923(j) of the Act's requirement that each State must submit annually the independent certified audit of its DSH program as a condition for receiving Federal payments under Section 1903(a)(1) and 1923 of the Act.

We proposed to add a new Sec. 455.204(b)to reflect the requirement that States must obtain an independent certified audit, beginning with an audit of its State fiscal year 2005 DSH program.

We proposed a submission requirement within 1 year of the independent certified audit.

We proposed that in the audit report, the auditor must verify whether the State's method of computing the hospital-specific DSH limit and the DSH payments made to the hospital comply with the five items required by Section 1923(j)(2) of the Act.

III. Discussion of Public Comments

On August 26, 2005, we set forth a proposed rule implementing the reporting and auditing requirements for State disproportionate share hospital payments (DSH). In this notice of proposed rulemaking, we proposed several modifications to the DSH reporting requirements and detailed the statutory auditing requirements for States to verify their methodology for computing the hospital-specific DSH limit to ensure that DSH payments made to eligible hospitals do not exceed such limits.

We received 119 timely public comments, in response to the August 26, 2005, proposed rule. The comments came from a variety of correspondents, including professional associations, national and State organizations, physicians, hospitals, advocacy groups, State Medicaid programs, State Legislators, and members of the Congress. The following is a summary of the comments received and our response to those comments.

Comments and Responses, except those dealing with Auditing, have been omitted from this document in the interests of brevity and for the fact that they are not necessary for accomplishing the audit requirements of this Contract.

Comments and Responses re. Auditing:

C. Auditing

1. General

Comment: Many commenters questioned the ability of the States to actually collect this information and have an independent audit completed within one year after the end of SFY 2005. One commenter said that demanding 2005 cost report data for SFY 2005 also means that most, if not all, of the cost report data forwarded to CMS will be as submitted by the hospitals because the States will not be able to review and audit the cost reports before the reporting deadline.

Response: The information required under the audit is readily available to hospitals and the State based on existing financial and cost reporting tools. As discussed above, we have revised the timing requirements to extend the length of time to submit required reports and audits to permit submission as late as the last day of the Federal fiscal year ending 3 years after the end of the Medicaid State plan rate year, with a special timing provision for the audits for 2005 and 2006, which will be due by December 31, 2009. We believe this accommodates most of these concerns. We also note that we expect that reports and audits will be based on the best available information. If audited Medicare cost reports are not available, the DSH report and audit may need to be based on Medicare cost reports as filed.

Comment: One commenter noted that most of the reporting requirements will require the hospital to report information directly to the State, and requested explanation of the State's due-diligence responsibility for confirmation/assurance of the completeness and accuracy of the data provided by the hospital?

Response: We expect that States will obtain needed information from the hospital's Medicare 2552-96 cost report, audited hospital financial statements, and other hospital accounting records, in combination with information provided by the States' Medicaid Management Information Systems.

Because these source documents are prepared for other purposes, no single document will contain the precise information needed for DSH reporting and auditing purposes. States will need to work with hospitals to develop a methodology that can be applied to these records to properly calculate uncompensated care costs incurred in furnishing hospital services for individuals without health insurance or other third party coverage. This methodology will need to exclude costs from the calculation costs for services furnished to individuals with third party coverage, prisoners, duplicate accounts, individuals included in calculating the Medicaid shortfall, charges associated with elective procedures, and any professional charges. The methodology must operate in such a way as to provide the State's independent auditor confidence that the data is an accurate representation of the hospital's eligible uncompensated care charge and revenue data.

Comment: A few commenters questioned access to hospital records and other jurisdictional issues. Such access would need to be discussed, decided and clarified for the States. State auditors may not have jurisdiction to audit private hospitals.

Response: States already have authority to obtain the primary data sources needed to complete the DSH audit and the accompanying report. Information can be obtained from existing cost reports and financial information. These documents would include the Medicare 2552-96 cost report, audited hospital financial statements, and hospital accounting records. States and auditors also have access to information from the States' Medicaid Management Information Systems. We expect that States and auditors will need to work with hospitals to develop a methodology that can be applied to these records to properly calculate uncompensated care costs incurred in furnishing hospital services for individuals without health insurance or other third party coverage.

Comment: A few commenters noted that although hospitals submit the newly required S-10 Worksheet (S-10) for their Medicare cost reports, the information required by that Worksheet does not directly parallel the data required in the new reporting requirements. In addition, although both seek determinations of hospitals' total uncompensated care costs, they apply different methodologies for calculating such costs. Thus, DSH recipients will be confronted with making one set of calculations for their annual reports and another for their State's annual DSH report. If States perform calculations with the requested data to determine DSH payments, why not discard (c)(6) through (c)(16), and instead request a copy of DSH payment calculations for all hospitals in a particular fiscal year? Each hospital's payment calculation could appear on separate pages or worksheets.

Response: Worksheet S-10 is not part of the Medicare 2552-96 step-down process used to allocate inpatient and outpatient hospital costs. The cost allocation process utilized in the 2552-96 cost report is considered a key component of determining Medicaid and uninsured hospital costs for purposes of calculating the hospital-specific DSH limit. The Medicare 2552-96 cost report, in conjunction with hospital financial information, including hospital accounting records and Medicaid Management Information Systems data, may be used to determine uncompensated care costs for the calculation of the hospital-specific DSH limits. We expect these calculations to rely primarily on existing information, as outlined in the General DSH Audit and Reporting Protocol that will be available on the CMS Web site. We recognize, however, there may be situations in which the hospital may have to work with the State to develop new data or methodologies to allocate or adjust existing data.

Comment: A few commenters said that currently, there is no one source of data to meet the increased reporting requirements. The sources of data are from various data warehouses and under various State and hospital management systems. The likelihood that data will not be from consistent data sets is possible.

Response: We expect these calculations to rely primarily on existing information, as outlined in the General DSH Audit and Reporting Protocol available on the CMS Web site. We recognize, however, there may be situations in which the hospital may have to work with the State to develop new data or methodologies to allocate or adjust existing data. And it may be necessary for auditors to develop methods to test, verify the accuracy of, and reconcile data from different sources. CMS has developed a General DSH Audit and Reporting Protocol available on the CMS Web site that may assist States and auditors to utilize information from each source identified above and develop the methods under which costs and revenues will be determined.

Comment: One commenter noted that one State Medicaid agency annually surveys all hospitals near the beginning of its fiscal year and hospitals report their data for a twelve month period, but this period does not match the State fiscal year. Further, the commenter noted difficulties in analyzing the data because Federal DSH payments are provided on a Federal fiscal year, and at changing match percentages. Another commenter indicated that another State's DSH payment program operates on a Federal fiscal year basis, which provides consistency with Medicare hospital payment systems, the timing of changes in their Federal financial participation rate and with the timing of their DSH allotment. These commenters noted that the requirement in the proposed regulation for States to report and audit their DSH and enhanced payment programs on a State fiscal year basis will cause significant administrative burden and will not accurately reflect the basis upon which the State is making payments.

Response: We have modified the regulation to indicate the Medicaid State plan rate year as the period subject to the annual audit. The basis for this modification is recognition of varying fiscal periods between hospitals and States. The Medicaid State plan rate year is the period which each State has elected to use for purposes of DSH payments and other payments made in reference to annual limits.

In instances where the hospital financial and cost reporting periods differ from the Medicaid State plan rate year, States and auditors may need to review multiple audited hospital financial reports and cost reports to fully cover the Medicaid State plan rate year under audit. At most, two financial and/or cost reports should provide the appropriate data. The data may need to be allocated based on the months covered by the financial or cost reporting period that are included in the Medicaid State plan period under audit.

CMS has developed a General DSH Audit and Reporting Protocol which will be available on the CMS Web site that may assist States in using the information from each source identified above and developing the methods under which costs and revenues will be determined.

Comment: Several commenters said this would be a reporting burden on Critical Access Hospitals and will distract from needed resources to provide services to the uninsured. One commenter noted that a reporting burden exists because hospitals may not keep self-pay collection logs.

Response: The DSH audit will primarily rely on existing financial and cost reporting tools currently used by all hospitals participating in the Medicare program and therefore, should not generally divert resources necessary to provide services to the uninsured. These documents would include the Medicare 2552-96 cost report, audited hospital financial information, and hospital accounting records in combination with information provided by the States' Medicaid Management Information Systems and the approved Medicaid State plan governing the Medicaid and DSH payments made during the audit period.

To the extent that hospitals do not separately identify uncompensated care related to services provided to individuals with no source of third party coverage from uncompensated care costs not eligible under the hospital-specific DSH limits, hospitals will need to modify their accounting systems to do so. Setting up an accounting category to aggregate charges and revenues associated with uninsured individuals receiving inpatient and/or outpatient services from a hospital should be an accounting system adjustment not far removed from the process of setting up an account for any other payer category.

For purposes of the initial audits, States and auditors may need to develop methodologies to analyze current audited financial information including hospital accounting records to properly segregate uncompensated costs.

Comment: A few commenters stated the regulation should provide more specificity about the level of precision expected in calculating the total cost of care. They noted that, due to the timing lag for reporting and auditing, some States use the hospital's latest available Medicare cost report to calculate that hospital's overall cost-to-charge ratio. In that instance, the commenters indicated that the State converts the Medicaid and uninsured charges to cost using the hospital's overall cost-to-charge ratio. The commenters also pointed out that relatively few hospitals have a cost reporting period that is the same as the State fiscal year and, therefore, there would be two cost reporting periods during a State fiscal year. The commenters asked if applying a hospital's latest available cost-to-charge ratio to that hospital's Federal fiscal year Medicaid and uninsured charges be an acceptable and reasonable method to calculate that total cost of care.

Response: We expect that State reports and audits will be based on the best available information. If audited Medicare cost reports are not available for each hospital, the DSH report and audit may need to be based on Medicare cost reports as filed. We note that hospitals must follow the cost reporting and apportionment process as prescribed by the Medicare 2552-96 cost report process. To the extent that these cost reports do not contain the precise information needed for the DSH calculation (for example, by not distinguishing the categories of uncompensated care costs that are needed), it may be necessary for hospitals to modify their accounting techniques. In those circumstances, for the initial audits, it will be necessary to review other source materials such as audited hospital financial records and other records, and to develop methodologies to determine the necessary information from such records. We expect States, independent auditors and hospitals to work cooperatively to develop such methodologies.

CMS has developed a General DSH Audit and Reporting Protocol which will be available on the CMS Web site that should assist States and auditors in utilizing information from each source identified above and developing methods to determine uncompensated costs of furnishing hospital services to the Medicaid and uninsured populations.

Comment: One commenter questioned how to identify, ``* * * costs incurred for furnishing those services provided to individuals with no source of third party coverage for the inpatient hospital and outpatient hospital services they receive.''

Response: CMS has developed a General Audit and Reporting Protocol to provide guidance to States, DSH hospitals and auditors in the completion of the DSH audit. This Protocol includes general instructions regarding the types of information to be provided by hospitals to the State and its auditor as well as the calculations the auditor will make based on the data provided. Specifically, the protocol details the process of using the Medicare 2552-96 cost report, hospital cost to charge ratios and hospital charges for inpatient and outpatient hospital services for which the recipient had no source of third party coverage. The protocol also details the process for determining eligible Medicaid uncompensated care for the Medicaid State plan rate year under audit. The protocol will be available on the CMS Web site.

Comment: One commenter noted that identifying uninsured patients is complicated by the restrictions on which uninsured patient accounts qualify (for example, if one cannot claim accounts denied due to medical necessity issues). This requires a painstaking and time-intensive process of reviewing each account history to identify the reason that an insurance company did not pay.

Response: To the extent that hospitals do not separately identify uncompensated care related to services provided to individuals with no source of third party coverage from uncompensated care costs not eligible under the hospital-specific DSH limits, hospitals will need to modify their accounting systems to do so. Setting up an accounting category to aggregate charges and revenues associated with uninsured individuals receiving inpatient and/or outpatient services from a hospital should be an accounting system adjustment not far removed from the process of setting up an account for any other payer category.

For purposes of the initial audits, States and auditors may need to develop methodologies to analyze current audited financial information, and hospital accounting records to properly segregate and identify DSH eligible uncompensated care costs.

Comment: One commenter noted that a State's Department of Social Services signed a Partnership Plan for the purpose of ``establishing a stable funding mechanism for the State's Medicaid program that embodies accountability while assuring the availability of financial resources to provide needed health care to the program's beneficiaries.'' The commenter noted that additional auditing and reporting requirements, as addressed in the proposed regulation, seem to be unduly burdensome and potentially costly to the State and the hospitals.

Response: Section 1923(j) of the Act contains audit and reporting requirements applicable to all States that make DSH payments. As part of this process, CMS must determine if all hospitals receiving DSH payments under the Medicaid State plan actually qualify to receive such payments and that actual DSH payments do not exceed the hospital-specific DSH limit for the same period.

To the extent that a State makes DSH payments within a Section 1115 waiver demonstration and/or a Partnership Plan, the State is not exempted from the rules surrounding DSH payments, particularly those at 1923(g) of the Act, and the audit and reporting requirements would still apply to that State.

It should be noted that the Partnership Plan primarily addresses funding of the Medicaid program, and is not relevant to the issue of whether particular payments are authorized under the approved Medicaid State plan and may be the basis for FFP under the Federal statute. Funding issues are not the subject of this regulation.

Comment: A few commenters suggested the creation of a $500,000 threshold of DSH payments before an in-depth audit pursuant to 42 CFR 455, new Subpart C is triggered. Many small hospitals have historically low DSH allotments, and the administrative costs of the proposed DSH reporting and auditing requirements are disproportionately onerous. If this exemption is not possible, the commenters request that any State with a DSH allotment under $500,000 be allowed to use a hospital's independent auditor attestation to meet the audit requirements for hospital data used in DSH calculations. A few commenters suggested that CMS consider evaluating whether the cost associated with detailed audits are justified and whether an audit that reviews a sample of hospitals annually might be just as effective and considerably less costly. One commenter recommended that the requirement be to verify that the State's calculation formula provides for inclusion of only uncompensated care costs of furnishing inpatient and outpatient hospital services to Medicaid eligible individuals and individuals with no source of third party coverage.

Response: There is no statutory authorization for an exception to audit and reporting requirements with respect to hospitals that receive low DSH payments. The audit and reporting requirements under Section 1923(j) of the Act apply to all States that make DSH payments, with respect to each hospital receiving a DSH payment. The statute further requires that CMS obtain information sufficient to verify that such payments are appropriate.

Relying on a sample of cost reports and financial information will not ensure that each DSH payment is appropriate and does not exceed the hospital-specific DSH limit.

The data elements necessary for the State to complete the DSH audit and report should, in part, be information the State already gathers to administer the DSH program. The responsibility of the auditor is to measure DSH payments received by a hospital in a particular year against the eligible uncompensated care costs of that hospital in that same year as determined using the data provided in the cost, utilization and financial reporting documents described above.

Finally, auditing a State's overall DSH payment methodology will not ensure that DSH payments to each hospital do not exceed the statutorily required hospital-specific DSH limit.

Comment: Commenting State Medicaid offices stated that the Medicaid program already represents a huge audit task for their offices, and that adding the additional responsibility of auditing hospital data for each hospital receiving a DSH payment would be an extremely large amount of additional work that would be nearly impossible to fit within required time frames. One commenter said that unless this requirement can be met through the acceptance of evidentiary documentation from the qualifying hospitals, further verification can only be made by the auditors' actual observation of the hospitals' records. The commenter complained that sending auditors to physically visit every qualifying hospital is onerous and expensive and the commenter questioned whether it is CMS' intent to require this extensive a drill-down.

Response: Section 1923(j) of the Act instructs States to audit and report specific payments and specific costs. The responsibility of the auditor is to measure DSH payments received by a hospital in a particular year against the uncompensated care costs for the Medicaid and uninsured populations incurred by that hospital in that same year. The auditor must follow accepted audit standards and develop sufficient confidence in the data to certify the results.

CMS has developed a General DSH Audit and Reporting Protocol to provide guidance to States, DSH hospitals and auditors in the completion of the DSH audit. This protocol provides general instructions regarding the types of information to be provided to the State and its auditor as well as the calculations the auditor will make based on the data provided. The Protocol will be available on the CMS Web site.

Comment: Several commenters's noted that a reconciliation that must be completed no later than one year after the completion of each State's fiscal year will place a substantial burden on hospitals. They asserted that this would mean that hospitals will have to provide the State with uncompensated care data for FY 2005 before it is required for the FY 2007 DSH computation. They further indicated that this is not practical, because uninsured patients are difficult to identify until all collection efforts with other payers have been pursued, which can take several years.

Response: As discussed above, we have revised the timing requirements to extend the length of time to submit required reports and audits to permit submission as late as the last day of the Federal fiscal year ending 3 years after the end of the Medicaid State plan rate year, with a special timing provision for the audits for 2005 and 2006, which will be due by December 31, 2009. We believe this accommodates most of these concerns. We also note that we expect that reports and audits will be based on the best available information. If audited Medicare cost reports are not available, the DSH report and audit may need to be based on Medicare cost reports as filed.

Comment: A few commenter's said that CMS should not impose unnecessary administrative burdens that will raise costs for * * * hospitals and States (that ultimately will be shared by the Federal Government) that result neither in improved quality or access nor in any measurable gain in accuracy or efficiency, particularly at this time when Congress and the Administration are intently focused on reining in Medicaid expenditures. They argued that diversion of scarce hospital resources from other productive activities to achieve, at best, only marginal gains in accuracy of the uncompensated care cost calculation should be reconsidered. The increased costs outweighing the benefit of the reconciliation mandate.

Response: Section 1923(g)(1)(A) of the Act specifies that DSH payments cannot exceed a hospital-specific limit. Section 1923(j) of the Act, as added by the MMA, instructed States to audit and report DSH payments made by States and compare those payments to the uncompensated care costs as set forth in that hospital-specific DSH limit. This regulation implements those statutory audit and report requirements and is not a discretionary agency action.

We expect that States and auditors will rely on existing financial and cost reporting processes currently used by all hospitals participating in the Medicare program and therefore should not create an undue burden on states and hospitals in reporting compliance with Federal Medicaid law.

CMS has developed a General Audit and Reporting Protocol to provide guidance to States, DSH hospitals and auditors in the completion of the DSH audit. This protocol provides general instructions regarding the types of information to be provided to the State and its auditor as well as the calculations the auditor will make based on the data provided. The Protocol will be available on the CMS Web site.

Comment: One commenter noted that neither the MMA nor the proposed rule clearly state if the independent auditor is providing an opinion on whether the State's calculation formula includes ``Only uncompensated care costs of furnishing inpatient and outpatient hospital services to Medicaid eligible individuals and individuals with no source of third party coverage * * *'', or whether the intent is for the independent auditor to perform an in-depth annual audit of the hospitals records and cost reports in order to verify the hospital reporting processes as well as audit the State's methodology.

One commenter questions whether the requirement is that each State hires an auditor to look at each hospital's uninsured calculations.

Response: Section 1923(j) of the Act, as added by the MMA requires States to audit and report on hospital-specific DSH payments and this rule makes clear that this obligation includes specific cost data. The responsibility of the auditor is to measure DSH payments received by a hospital in a particular year against the eligible uncompensated care costs of that hospital in that same year.

States and auditors will need to obtain data from hospitals and may need to work with hospitals to develop new data or methodologies to allocate or adjust existing data. And it may be necessary for auditors to develop methods to test, verify the accuracy of, and reconcile data from different sources. This audit function is not the same as the function of the hospital's own auditors, however, and would not involve a review of the hospital's financial controls and internal reporting procedures. But the auditors must review the overall methodology for accumulating data to ensure that the resulting data reflects the required elements. In other words, the independent auditors must review the methodology for arriving at hospital-specific data, and must have confidence that the data accurately represents the hospital's eligible uncompensated care costs consistent with the statutory criteria.

Comment: One commenter said that in their State hospital representatives are required to sign a survey of data for DSH purposes, in order to certify that the data is accurate and in accordance with hospital records. There is a requirement that hospitals maintain the supporting documentation for potential audits. The commenter asked if this process was sufficient or whether all the supporting documentation needed to be housed at the Medicaid agency.

Response: Section 1923(j) of the Act requires audit and report of hospital-specific DSH payments and hospital-specific uncompensated care costs. While survey data submitted by the hospital may be an important source of information, the auditors may need to examine the methodology followed to arrive at that survey data, and may need to develop methods to test, verify the accuracy of, and reconcile data from different sources. One ultimate responsibility of the auditor is to compare DSH payments received by a hospital in a particular year with the actual eligible uncompensated care costs incurred by the hospital in that same year. Unreviewed survey data is not sufficient to satisfy the statutory instruction of the MMA.

CMS has developed a General DSH Audit and Reporting Protocol to provide guidance to States, DSH hospitals and auditors in the completion of the DSH audit. This protocol provides general instructions regarding the types of information to be provided to the State and its auditor as well as the calculations the auditor will make based on the data provided. The Protocol will be available on the CMS Web site.

Comment: Many commenters's stated that the auditing requirements are costly and burdensome to both the hospitals and the State, creating another source of disincentive to hospital participation. The commenter's request CMS be mindful of the additional financial costs that hospitals would incur and compensate hospitals accordingly.

Response: CMS believes that audits will rely primarily on documents already available to hospitals, and thus the audit data burden will neither be significant nor costly. CMS also believes that it is unlikely that a hospital will decline to receive Medicaid DSH payments merely because they must provide information to the State to verify that DSH payments do not exceed the hospital's DSH eligible uncompensated care costs.

Comment: One commenter asked whether the ``independent audit'' is a financial audit, or an audit of agreed-upon procedures. The commenter indicated that, if it is an audit of agreed-upon procedures, it would be helpful if audit program and procedures clarification were provided by CMS.

Response: The purpose of the audit is to ensure that States make DSH payments under their Medicaid program that are in compliance with Section 1923 of the Act. The nature of the audit encompasses both program and financial elements making it impossible to label as a traditional financial or programmatic/governmental audit.

The audit review of the State's Medicaid program is limited to ensuring that DSH payments are consistent with the approved Medicaid State plan and Federal statutory limits. The DSH audit will rely in part on financial, accounting and cost report data provided by hospitals. This data should be subject to generally accepted accounting principles, and auditors may need to verify the methodology used for calculating such data. These financial elements will demonstrate that Federal payments were claimed in compliance with Federal statutes.

Comment: One commenter's opinion about the most practical manner in which the State could meet this regulation is to require hospitals to expand their current financial audits to include the appropriate hospital-related compliance issues and have their uncompensated care data audited as part of their annual financial statement audit. Auditors of the Medicaid program (as part of the State's Single Audit) could then rely on these audited certifications and evaluate each State's DSH payment calculations and other information being reported by the State to the Secretary.

Response: The statute places audit and reporting requirements upon States, and these regulations reflect those requirements. These regulations do not impede States from developing procedures to meet these requirements that place particular burdens on hospitals receiving DSH payments. For example, States may establish procedures for hospitals to provide detailed audited data that can be relied on by the independent certified DSH auditors. We do not agree that these procedures can completely substitute for an independent certified audit obtained by the State itself. Nor do we agree that the State's single audit can substitute for the DSH audit responsibility under Section 1923(j) of the Act. The purpose of the State's single audit is different from the DSH audit responsibility, and we read the statute to require a distinct, focused review of DSH payments.

Comment: Several commenters' recommend that CMS accept the current audit processes of their State. One commenter said that hospitals in the State that are currently required to complete annual certified independent audits of their uncompensated care data are only required to perform audits using generally accepted accounting principles and strongly recommended that the definition be changed so that audits may be performed under those principles already in place for a hospital's audited financial data. The hospitals of some States already independently certify uncompensated care data submitted o the State and submit these audited financial statements along with their annual cost reports. The information in the cost reports comes from the hospitals' accounting systems that have been independently audited. Another commenter recommended that CMS exempt States with satisfactory independent certification programs already in place from this provision.

Response: The statute places audit and reporting requirements upon States, and these regulations reflect those requirements. These regulations do not impede States from developing procedures to meet these requirements hat place particular burdens on hospitals receiving DSH payments. For example, States may establish procedures for hospitals to provide detailed audited data that can be relied on by the independent certified DSH auditors. We do not agree that these procedures can completely substitute for an independent certified audit obtained by the State itself. Nor do we agree that the State's single audit can substitute for the DSH audit responsibility under Section 1923(j) of the Act. The purpose of the State's single audit is different from the DSH audit responsibility, and we read the statute to require a distinct, focused review of DSH payments.

Comment: Numerous commenters's noted that the proposed requirement that the audit must be conducted pursuant to the government auditing standards is unduly burdensome. Most auditors in the private sector use generally accepted accounting principles (``GAAP'') to audit hospitals' financial data. Thus, the independent auditors involved in performing hospital audits and who use the GAAP standards to do these audits may not even be familiar with the generally accepted government auditing standards. In any case, it is inefficient to require these auditors to perform another audit of the same data using different auditing standards. At a minimum, States or hospitals should be allowed to use either the GAAP standards or the government auditing standards in meeting the audit requirements.

Response: Generally Accepted Government Auditing Standards (GAGAS) are the principles governing audits conducted of government organizations, programs activities, functions or funds. In general, government audits are either performance audits or financial audits. In either type, the focus is on the government entity, its management of a program and/or the financial management and reporting systems associated with that program.

The fact that there are some differences between GAGAS and GAAP, however, is a further reason why hospital audit efforts and the DSH audit have separate focuses and require separate analyses.

The DSH audit and report is a statutorily required component in the administration of the Medicaid program. The purpose of the audit is to ensure that States make DSH payments under their Medicaid program that are in compliance with Section 1923 of the Social Security Act. The audit does not encompass the review of the State's Medicaid program, it simply ensures that one portion of the program is conducted in line with Federal statutory limits. In addition, the DSH audit will rely on financial and cost report data provided by hospitals that are subject to generally accepted accounting principles as part of their primary reporting function.

Comment: One commenter said some auditors may find that base year figures cannot be verified to the extent necessary to provide a valid base because data or audit trails not previously necessary, are now required.

Response: States and auditors will need to obtain data from hospitals and may need to work with hospitals to develop new data or methodologies to allocate or adjust existing data. And it may be necessary for auditors to develop methods to test, verify the accuracy of, and reconcile data from different sources.

Comment: One commenter noted that the proposed rule appears to have greatly expanded the required scope (of Section 1923(j)(2)(E)) by making the State responsible for retaining documentation of patient-specific data. Assuming that CMS does not intend to place such a reporting burden on the States, the commenter requested that CMS clarify that the documentation requirement for hospital-reported data is limited to collecting, documenting and retaining State data and does not include documentation for data that a hospital might otherwise have available.

Response: States and auditors will need to work with hospitals to determine the extent to which original patient-specific source data is required and needs to be retained by the State.

2. Timing of Payments Under Review

Comment: A few commenters's questioned whether DSH payments made by a State after SFY 2005 for dates of services prior to SFY 2005 are subject to the new auditing and reporting requirements. They noted that, currently, a few States make DSH payments after receipt of settled cost report from the Medicare fiscal intermediary and applies the DSH allotment based on dates of service. For example, one State made its DSH payment in SFY 2003 for dates of service in 2000 (using the 2000 Federal DSH allotment and settled Medicare cost reports).

Response: Unless otherwise specified in a State plan, the year in which payment is contemplated and accrues (even when subject to adjustment) is the DSH rate year to which it applies. Many States have provisions that provide for DSH payments based on prior year data, but that does not mean that those payments are prior year payments. (In the cited example, if that was the case, then the effect of any change in the DSH payment methodology would take three years to result in payment changes.) Each State should be aware of the Medicaid State plan rate year for which a DSH payment is made.

Comment: A few commenters's said while Medicaid related data is readily available directly to the State, data regarding Medicare payments and discharges and non-Medicaid/non-Medicare data is not readily available to the State in efficient formats and timeframes required by the proposed rule.

Response: The commenter specifically questions the availability of non-Medicaid hospital data necessary to complete the audit. The only non-Medicaid related data relevant for the DSH audit would be the inpatient and outpatient hospital charges to individuals with no source of third party coverage. This information is available in hospital accounting records. Since the deadline for reporting the audit findings has been extended to at least three full years after the close of the Medicaid State plan rate year subject to audit, hospitals would have necessarily included this charge data in their as-filed Medicare cost reports.

Comment: One commenter noted it would avoid misunderstanding if CMS clarified whether the required data element refers to gross revenue (full charges for services) or net revenue (expected collections after revenue adjustments.)

Response: Uncompensated care costs under the hospital-specific DSH limit are calculated by reducing costs incurred in furnishing hospital services to the Medicaid and uninsured populations, reduced by revenues received under Medicaid (not including DSH payments) and further reduced by payments received from or on behalf of the uninsured population (not including payments made by a State or local government for services to indigent patients).

Comment: Many commenter's recognized that the proposed regulations are effective for SFY 2005 and stated it is inappropriate to require an audit for SFY 2005, when the rule outlining the required data to be audited had only been proposed two months after the close of SFY 2005 (August 26, 2005). The commenter's urged a prospective application of these requirements effective for the first State fiscal year that begins after the date the final rule is issued, to allow sufficient time for respondents to identify data being required and processes to accumulate such data. A few commenter's said the proposed regulation is impossible for both States and hospitals from an operational standpoint because this methodology uses actual costs and payments, and because of the deadlines for the audits and reports, neither Medicaid payments nor audited cost information are available. Numerous commenters's stated that should CMS require an independent audit, it would be virtually impossible for States to meet the one-year filing deadline.

Response: The statutory provision at Section 1923(j) of the Act requires audits and reports for fiscal year 2004, but we are implementing this provision prospectively with Medicaid State plan rate year 2005, because that is the first Medicaid State plan rate year that necessarily begins in or after Federal fiscal year 2004. With that clarification, and because audits are prospective activities, we do not believe this rule has any retroactive effect. Moreover, as discussed above, CMS has modified the regulation to address the timing concerns expressed by these commenter's. The regulation has been modified to:

1. Identify the Medicaid State plan rate year 2005 as the first time period subject to the audit requirement.

2. Extend the time period for submission of completed audit reports to the last day of the Federal fiscal year (FFY) ending three years from the Medicaid State plan rate year under audit. This means that the 2007 Medicaid State plan rate year must be audited by the last day of FFY 2010.

3. Provide for a special transition time period for concurrent completion of Medicaid State plan rate year 2005 and 2006 audits by September 30, 2009.

4. Provide for submission of each audit report within 90 days of the completion of the audit.

5. Provide for a transition period for reliance on audit findings, so that audit findings will not be given weight until Medicaid State plan rate year 2011 and thereafter in calculating uncompensated care cost estimates and associated DSH payments.

Comment: Many commenters's said that this requirement could not be met if the regulations required a retrospective audit, because final settlement of hospitals' cost reports is typically contingent upon completion by a Medicare intermediary of audits that can take several years. One commenter noted that the requirement that the certified audit be completed one year after the close of the fiscal year is unattainable because the majority of the data required can only be derived from the Medicaid cost report, which is submitted no sooner than five months after the end of the fiscal year. Given the detail involved in the audit, the commenter's indicated that there will not be enough time to receive cost reports, review and settle the reports, and provide data to the auditor, who would need to certify this tentatively settled cost report data for each of the States' DSH providers. One commenter stated that the regulation should be clarified to permit the required report to be based on a hospital's as-filed cost report, and time should be allowed for States to collect the additional data needed to meet the reporting requirements. One commenter said the hospitals in the State accumulate and report costs based on the hospital's fiscal year utilizing the audited Medicare cost report (HCFA-2552-96) which is generally not available before 21 months after the hospital's year end. Moreover, the commenter indicated that such reports do not use the same fiscal year as the SFY, and thus the cost information is not available on a SFY basis. The commenter's also indicated that timing issues are also complicated by the fact that Medicaid claims may be submitted by hospitals to the State up to one year after the date of service.

Response: We discussed above the revisions made to address comments on timing issues and extend the time frames for reporting and auditing requirements. We expect that reports and audits will be based on the best available information. If audited Medicare cost reports are not available, the DSH report and audit may need to be based on Medicare cost reports as filed. We recognize that, in many instances, hospital financial and cost report periods will differ from the Medicaid State plan rate year. In these instances, States and auditors may need to use multiple audited financial reports and hospital cost reports (CMS 2552-96, finalized when available or as-filed) to fully document the appropriateness of DSH payments for the Medicaid State plan rate year under audit. The data would then be allocated based on the months covered by the financial or cost reporting period that are within the Medicaid State plan period under audit. For instance, if a Medicaid State plan rate year runs from July 1, 2004 through June 30, 2005, but a DSH hospital receiving payments under the Medicaid State plan operates its financial and cost reporting based on a calendar year, the State and auditors may need to use information from financial and cost reports for calendar years 2004 and 2005. Costs and revenues of serving the Medicaid and uninsured populations would be allocated from each financial and cost reporting period, in this case half from each report, to determine the data for Medicaid State plan rate year 2005.

Comment: One commenter said that due to delays in receiving settled cost reports from Medicare Intermediaries, a State may distribute more than one year of DSH payments to hospitals in a given State Fiscal Year. The commenter asks for confirmation that the State should submit a separate Annual DSH Report for each year of DSH payments, regardless of the date of DSH payment.

Response: The DSH Audit must be performed and reported to CMS on an annual basis, which should reflect the basis for all DSH payments made for the Medicaid State plan rate year, even if the DSH payment for that period is made in a subsequent year.

Comment: A few commenters's questioned whether a detailed audit manual should be prepared by CMS in order to assure compliance with the rule when promulgated and to avoid disputes after payments have been made.

Response: CMS has developed a General DSH Audit and Reporting Protocol to provide guidance to States, DSH hospitals and auditors in the completion of the DSH audit. This Protocol includes general instructions regarding the types of information to be provided by hospitals to the State and its auditor as well as the calculations the auditor will make based on the data provided. The Protocol will be available on the CMS Web site.

3. Audit Objective and Data Sources

Comment: Several commenters's expressed their opposition to the audit aspect of the proposed regulation. While recognizing the need for audits, the commenter's believe that the audits should fulfill only the following three objectives: determine whether individual States are following their own formulas for the calculation of DSH payments and hospital-specific DSH payment limits; verify the accuracy of States' calculations; and determine whether individual States are making good-faith efforts to make those calculations in compliance with Federal guidelines. The commenter's believe the proposed regulation exceeds these three objectives. The commenter's hope that CMS will instruct auditors that there are, in fact, various ways for States to make these calculations while remaining in compliance with Federal guidelines.

Response: Section 1923(j) of the Act requires that States audit actual DSH payments made under the approved Medicaid State plan against actual eligible uncompensated hospital costs in the same time period. Hence, the audit requirement necessarily will measure whether DSH payments made under the formulas in the approved Medicaid State plan are within the hospital-specific DSH payment limits as calculated by the State. The Medicaid State plan includes the reimbursement methodologies States utilize to make Medicaid DSH payments. While States typically include a provision within the Medicaid State plan that such payments will not exceed each qualifying hospital's DSH limit, such reimbursement methodologies do not identify cost components that are necessary for calculation of the hospital-specific DSH limits. Instead, States often for payment purposes rely on survey data reported by DSH hospitals to calculate hospital-specific DSH limit, data which is not typically audited by States to ensure compliance with the statutory limits on DSH payments.

While CMS recognizes that States must use estimates to determine DSH payments in a given Medicaid State plan rate year, Section 1923(j) of the Act requires confirmation that such payments do not exceed the cost limitations imposed by Congress under the Omnibus Budget Reconciliation Act of 1993.

Comment: A few commenters's suggested the regulation should clarify the source for the information to be provided for the audit, particularly as it pertains to the payments made for the services. The commenter's specifically asked whether the information should be on discharges during a State fiscal year (Medicare pays based on discharges), admissions during a State fiscal year (some States pay based on admissions), or actual payments made during the State fiscal year regardless of when the services were provided.

Response: Section 1923(j) of the Act requires states to report and audit hospital-specific DSH payments and hospital-specific uncompensated care costs. To meet this requirement, States must perform audits associated with defined periods of time and must identify the actual costs incurred and payments received during that defined time period.

As noted previously, we expect that States and auditors will obtain information whenever possible from existing sources. States and auditors should use consistent practices in their reports and audits. Because each State uses different hospital payment methodologies, there is no national rule on whether, for example, admissions or discharges should be used to measure whether services were furnished within a Medicaid State plan rate year. The same methodology should be used to measure uncompensated care costs as is used in determining payments under the Medicaid State plan.

CMS has developed a General DSH Audit and Reporting Protocol will be available on the CMS Web site to assist States and auditors in developing methodologies to use existing sources of information to determine uncompensated care costs in furnishing hospital services to the Medicaid and uninsured populations.

Comment: A few commenter's stated they currently have no way of verifying payments to hospitals by Medicaid managed care organizations for inpatient and outpatient hospital services furnished to Medicaid eligible individuals because payments to hospitals are paid directly by the managed care plans. The commenter's indicated that States have no first hand knowledge, and no claims documentation regarding these payments. The commenter's questioned whether CMS would accept the use of self-reported hospital financial information that references these payments in total for purposes of the Annual DSH Reports.

Response: There are three specific types of revenues that must be included in the audit to which the State conducting the audit will not have direct access. They are: (1) Medicaid and DSH payments received by the hospital from a State other than the State in which the hospital is located; (2) Medicaid MCO payments; and, (3) uninsured payments. The State must rely on hospital audited financial statements and hospital accounting records for this information. The State's Medicaid Management Information System has the most central and current information for in-State Medicaid fee-for-service inpatient and outpatient hospital payments, Medicaid supplemental and enhanced payments and DSH payments and will be the source of such payment.

In addition, hospital cost information is available only from a reporting DSH hospital. The State and CMS must rely on hospital Medicare 2552-96 cost reports to provide this information.

Comment: One commenter requested CMS clarify that it is acceptable to report data for a recent prior period, with appropriate adjustments for expected changes between the data collection period and the DSH reporting period.

Response: We read the report and audit requirements to call for actual data, rather than estimated data. To accommodate the delays in obtaining data, we have extended the deadlines for submission of the reports and audits. While CMS recognizes that States must use estimates to determine initial DSH payments in a given Medicaid State plan rate year, Section 1923(j) of the Act requires confirmation that such payments do not exceed the cost limitations imposed by Congress under the Omnibus Budget Reconciliation Act of 1993. We do not believe estimates are sufficient to meet this requirement.

Comment: One commenter questioned the ramifications of reporting costs and payments in out-of-State and border hospitals, and asked whether the audit team would be responsible for DSH amounts for only hospitals in the State or for all hospitals (in State and out of State) that received Medicaid DSH dollars from that State. The commenter suggested that, in order to avoid duplicate payments, CMS should outline a methodology to be utilized when auditing hospitals that receive DSH payments from more than one State.

Response: A State is required to audit DSH payments and eligible uncompensated care costs for only those DSH hospitals that are located within the State. This method will allow the auditor to recognize DSH payments received by a hospital from other States in addition to the DSH payments received by that hospital under the ``home-State's'' approved Medicaid State plan.

For States that make DSH payments to hospitals located in other States, the State must include in the reporting requirements the DSH payments made to hospitals located outside of the State, but would not be required to audit those out-of-State DSH hospital's total DSH payments/total eligible uncompensated care costs. This method will ensure that no DSH hospital is audited more than one time per year for purposes of the DSH auditing and reporting requirements under the MMA.

Comment: Many commenters's noted that the DSH program has allowed hospitals to extend access to healthcare for many poor and uninsured individuals. They noted that the new requirements include significant administrative expenses and responsibilities to both the States and hospitals. Several State Medicaid Agencies were concerned that a likely outcome will be that hospitals decline to participate in the DSH program, resulting in a decline in the delivery of healthcare services to the uninsured citizens and the patients treated from some Indian Reservations.

Response: CMS does not believe that the audit data burden will be significant since the audit relies on documents already available to hospitals. CMS also believes that it is unlikely a hospital will decline to receive Medicaid DSH payments for uncompensated care simply because the hospital must provide information to the State to assist in the verification that DSH payments do not exceed the hospital's eligible uncompensated care costs as required by Federal law.

The State is responsible for the administration of its Medicaid program and the successful completion of the DSH audit as part of that administration. Costs associated with the audit are eligible for Federal administrative matching funds.

Comment: Many commenters's stated it would be extremely labor intensive and an excessive reporting burden for (DSH) hospitals to match payments received from individuals to payments received for individuals for which there was no third party coverage because it does not currently do that automatically.

Response: To the extent that hospitals do not separately identify uncompensated care related to services provided to individuals with no source of third party coverage for the inpatient and outpatient hospital services they receive from uncompensated care costs not eligible under the hospital-specific DSH limits, hospitals will need to modify their accounting systems prospectively to do so. Setting up an accounting category to aggregate charges and revenues associated with uninsured individuals receiving inpatient and/or outpatient services from a hospital should be an accounting system adjustment not far removed from the process of setting up an account for any other payer category.

For purposes of the initial audits, States and auditors may need to develop methodologies to analyze current audited hospital financial statements and hospital accounting records to properly segregate uncompensated costs.

Comment: Many commenters' have stated that it is unclear who must pay for the audit.

Response: The DSH audit and report is a necessary element in the administration of the Medicaid program. The cost of the audit is the responsibility of the State and can be matched by the Federal Government as a Medicaid administrative cost of the State.

Comment: Several commenters's noted the proposed requirement for the independent certified audits is unduly burdensome. Several States have had in place for a number of years a requirement that hospitals submit certified public audit or certifications of hospitals' uncompensated care data. This is followed by the single State audit of State's DSH program which tests and verifies all of the elements that are currently required by the DSH state plan and State law requirements. To impose an additional layer of auditing at considerable expense to States is unnecessary.

Response: Section 1923(j) of the Act requires States to audit actual DSH payments made under the approved Medicaid State plan against actual eligible uncompensated hospital costs in the same time period. Hence, the audit requirement will necessarily measure whether payments made under the formulas in the approved Medicaid State plan are within the hospital-specific DSH payment limits as calculated by the State. The certification required in the regulation is a certification of the audit performed to determine compliance with the hospital-specific limitations imposed by Section 1923 of the Act.

While the DSH audit will rely on existing financial and cost reporting tools currently used by all hospitals participating in the Medicare program including audited hospital financial statements, hospital accounting records and the Medicare 2552-96 cost report, these source documents simply provide data to the auditor. Certification of these source documents is not sufficient to ensure that DSH payments do not exceed the hospital-specific limits and would not allow CMS to carry out the intent of the law which was to ensure that each DSH hospital will not exceed its hospital-specific limit. The independent certified audit will verify that the DSH payments authorized under the approved Medicaid State plan are within the hospital-specific DSH limits defined under Federal law.

Comment: Several commenters requested clarification regarding who is responsible for obtaining the independent audit and ensuring the requirements are met. For example, it could be presumed that these audit requirements are the responsibility of the State's auditor, the State Medicaid program's auditor, the Medicaid agency's staff or their agent, or the hospital's auditor.

A few commenters said it is not clear what constitutes ``independent,'' and propose that CMS consider ``independent audit'' to mean an audit independent of the hospital that does not require the State to contract with a private-sector auditing firm to complete and certify. One commenter questioned whether the terms in the rule stating that the audit must be independent and certified presumes that a certified public accountant or comparable professional must perform the audit or is the State allowed to engage the services of a contractor with different skill sets as long as the auditor is independent? One commenter questioned whether ``independent audit'' means that a State may employ its current outside auditors to conduct audit and reporting requirements required by the proposed regulations, recognizing that audit programs will be modified to meet the additional auditing and reporting requirements demanded?

Response: The term ``independent'' means that the Single State Audit Agency or any other CPA firm that operates independently from either the Medicaid agency (or other agency making Medicaid payments) or the subject hospital(s) may perform the DSH audit. States may not rely on non-CPA firms, fiscal intermediaries, independent certification programs currently in place to audit uncompensated care costs, nor expand audits of hospital financial statements to obtain audit certification of the hospital-specific DSH limits.

Section 1923(j) of the Act requires States to report and audit specific payments and specific costs. The responsibility of the auditor is to measure DSH payments received by a hospital in a particular year against the eligible uncompensated care costs of that hospital in that same year. Certification means that the independent auditor engaged by the State reviews the criteria of the Federal audit regulation and completes the verification, calculations and report under the professional rules and generally accepted standards of audit practice. This certification would include a review of the State's audit protocol to ensure that the Federal regulation is satisfied, an opinion for each verification detailed in the regulation, a determination of whether or not the State made DSH payments that exceeded any hospital's specific DSH limit in the Medicaid State plan rate year under audit. The certification should also identify any data issues or other caveats that the auditor identifies as impacting the results of the audit.

Comment: Several commenters believe the most practical manner in which the State could meet this audit regulation is by requiring hospitals to have their uncompensated care data audited as part of their annual financial statement audit. Auditors of the Medicaid program (as part of the State's Single Audit) could then rely on these audited certifications and evaluate each State's DSH payment calculations and other information being reported by the State to the Secretary. Numerous commenters stated it would be more efficient and less burdensome for the individual hospitals to make the required verifications for their own financial data. Most hospitals already have their financial information reviewed and certified by an independent auditor, so the auditor could complete these verifications as part of the standard audit process. One commenter stated it is not clear if audit procedures applied in any other audits the hospital has undergone would be sufficient to rely upon in this verification. One commenter suggests that data submitted by a hospital which has had its own independent audit be considered ``certified'' for the independent audit requirements of this rule.

Response: States may not rely on independent certification programs currently in place to audit uncompensated care costs nor expand audits of hospital financial statements to obtain audit certification of the hospital-specific DSH limits. Section 1923(j) of the Act MMA imposes audit and reporting requirements on States. CMS must determine if all hospitals receiving DSH payments under the Medicaid State plan actually qualify to receive such payments and that actual DSH payments do not exceed the hospital-specific limit for the same period. The certification required in the regulation is a certification of the audit performed to determine compliance with Section 1923 of the Social Security Act.

While the DSH audit will rely on existing financial and cost reporting tools currently used by all hospitals participating in the Medicare program including audited hospital financial statements, hospital accounting records, and the Medicare 2552-96 hospital cost report, these source documents simply provide data to the auditor. Certification of source documents or uncompensated care cost programs is not sufficient to ensure that DSH payments do not exceed the hospital-specific limits and would not allow CMS to carry out the intent of the law which was to ensure that each DSH hospital will not exceed its hospital-specific limits.

Comment: Several commenters indicated that most of the requirements outlined in the proposed regulations require data that will be obtained from hospital cost reports. The commenters questioned whether the States will be responsible for completing individual hospital audits in greater detail prior to completing the DSH report. One commenter questioned whether having the data audited by an independent audit firm engaged by the DSH hospitals would satisfy the independent audit requirement, or whether States would be required to audit the data?

Response: We anticipate that the audit will rely primarily on already available documents. The State and auditors can use data extracted from existing hospital cost and financial reporting tools supplemented with State generated data from the State's Medicaid Management Information System. The data elements necessary for the State to complete the DSH audit and report should, in part, be information the State already gathers to administer the DSH program.

States and auditors will need to obtain data from hospitals and may need to work with hospitals to develop new data or methodologies to allocate or adjust existing data. And it may be necessary for auditors to develop methods to test, verify the accuracy of, and reconcile data from different sources. This audit function is not the same as the function of the hospital's own auditors, however, and would not involve a review of the hospital's financial controls and internal reporting procedures. But the auditors must review the overall methodology for accumulating data to ensure that the resulting data reflects the required elements. In other words, the independent auditors must review the methodology for arriving at hospital-specific data, and must have confidence that the data accurately represents the hospital's eligible uncompensated care costs consistent with the statutory criteria.

Comment: A few commenters’s indicated that many States have invested an increasing amount of time and expense managing Federal audits and presumed the increased audit requirements would be at the States' expense.

Response: CMS does not believe the audit data burden will be that significant since the audit may rely primarily on already available documents. The State and auditors can use data extracted from existing hospital cost and financial reporting tools supplemented with State generated data from the State's Medicaid Management Information System. The data elements necessary for the State to complete the DSH audit and report should, in part, be information the State already gathers to administer the DSH program. The State would incur additional cost associated with engaging an auditor but that cost is eligible for Federal administrative matching funds.

Comment: One commenter stated that using an independent auditor would add administrative costs to the Medicaid program. The State requests CMS to confirm if DSH funds can be used to fund the cost of the audit, and if the State can claim FFP at the DSH matching rate.

Response: State costs of the audit are administrative costs of the Medicaid program, and not DSH costs. The DSH program was established by Congress to help offset uncompensated inpatient and outpatient care provided by hospitals to Medicaid individuals and the uninsured. States may not access Federal DSH funding for purposes other than reimbursing hospitals for unreimbursed inpatient and outpatient services provided to Medicaid individuals and individuals with no source of third party coverage for the inpatient and outpatient hospital services they received.

The DSH audit and report is a necessary element in the administration of the Medicaid program. The State is responsible for the successful completion of the DSH audit as part of that administration. Costs associated with the audit are eligible for Federal administrative matching funds.

Comment: Numerous commenters’s noted that the proposed rule does not address how the audits will be paid for and there is a concern that the State Medicaid programs will pass on these additional costs to DSH hospitals. The commenter’s recommended that CMS state affirmatively that the cost of the audits should not be passed on to hospitals. A few commenters’s noted that since the cost of auditing each DSH hospital's records to satisfy the new audit requirements will be substantial and recommended it be funded by a special appropriation to the States for such purpose. Many commenters’s recommended that CMS reconsider its conclusion that the regulation would not have a significant economic impact and should undertake appropriate analyses under Executive Order 12866 and the regulatory impact analysis to consider how the burden on hospitals could be lessened.

Response: We still do not believe that this regulation will impose a significant impact. The final rule allows the DSH audits to be part of a hospital's existing annual financial. If this is the case, the costs to the hospital should be minimal since the annual hospital financial audit is already a requirement. States are responsible for the administration of their Medicaid programs and the successful completion of the DSH audit as part of that administration.

Comment: Numerous commenters’s indicated significant confusion regarding the mechanics of compliance with the requirement for States to have DSH payment programs independently audited annually and to submit those certifications annually to the DHHS Secretary. The commenter’s requested further guidance and explicit details of standards and procedures required by CMS.

Response: As a condition of continued Federal DSH funding, pursuant to Sec. 455.204, States will need to be in compliance with audit and reporting requirements. CMS has developed a General DSH Audit and Reporting Protocol which will be available on the CMS Web site to assist States and auditors in utilizing information from each source identified above and the methods under which costs and revenues will be determined. In addition, an auditing and reporting schedule is described in earlier responses to comments and is also included in the final regulation.

Comment: A few commenters’s noted that their States have experienced numerous difficulties when contracting with external auditing firms. Subjecting each hospital's DSH data to another audit at the State level would be an extremely time-consuming and very expensive process for the State would not add any value to the auditing process.

Response: The DSH audit and report is a necessary element in the administration of the Medicaid program. The State is responsible for the successful completion of the DSH audit as part of that administration. Costs associated with the audit are eligible for Federal administrative matching funds.

The term ``independent'' means that the Single State Audit Agency or any other CPA firm that operates independently from the Medicaid agency and the subject hospitals may perform the DSH audit. States may not rely on non-CPA firms, fiscal intermediaries acting as agents for a State's Medicaid program, independent certification programs currently in place to audit uncompensated care costs, nor expand hospital financial statements to obtain audit certification of the hospital-specific DSH limits.

States may use Medicaid agency auditors to gather the data and perform initial data analysis for the DSH audit. However, the audit must be certified by an independent auditor as described above.

Comment: One commenter questioned whether it is CMS' intent to prevent an independent CPA firm, contracted by a State to audit Medicaid cost reports on the State's behalf, from being able to audit that same state's DSH program through the independence requirements of the Government Auditing Standards. If so, the commenter questioned if any contract with a State's Medicaid agency would impair the independence of a CPA firm in performing the DSH audit required in the rule.

Response: The intent of the requirement that States use independent auditors to certify the DSH audit is to provide a quality end product based on consistently applied auditing standards to produce unbiased findings. An independent auditor must operate independently from the Medicaid agency and the subject hospitals. The fact that a CPA firm contracts with the Medicaid agency to audit Medicaid cost reports does not disqualify that firm from being considered independent and therefore qualified to perform the DSH audit as long as the contract permits the auditor to exercise independent judgment.

Comment: Many commenters's questioned whether the State audit agency would be appropriate for a certified independent audit according to generally accepted government auditing standards. If an independent audit of each facility is required, the commenter's asked if State Medicaid program auditors would be considered independent to perform the hospital portion of the work.

Response: The term ``independent'' means that the Single State Audit Agency or any other CPA firm that operates independently from the Medicaid agency or subject hospitals is eligible to perform the DSH audit. States may not rely on non-CPA firms, fiscal intermediaries acting as Agents for a State's Medicaid program, independent certification programs currently in place to audit uncompensated care costs, nor expand hospital financial statements to obtain audit certification of the hospital-specific DSH limits.

States may use Medicaid agency auditors to gather the data and perform initial data analysis for the DSH audit. However, the audit must be certified by an independent auditor as described above.

Comment: A few commenters's stated that the financial effectiveness of the audits would be enhanced if the Medicare fiscal intermediaries were available to do the audits. Intermediaries provide services at a lower cost than private accounting firms. Time world be saved because the intermediaries have all the necessary information. This may also be helpful to States that require a lengthy procurement bidding process.

Response: States may contract with Medicare fiscal intermediaries to the extent that the Medicare fiscal intermediary meets the definition of an independent CPA firm and operates under a contract that ensures independent judgment. The term ``independent'' means that the Single State Audit Agency or any other CPA firm operates independently from the Medicaid agency or subject hospitals.

Comment: One commenter questioned whether it would be appropriate for the State's Auditor General's office to perform the independent audit of DSH Payments using the Generally Accepted Government Auditing Standards.

Response: The term ``independent'' means that the Single State Audit Agency or any other CPA firm that operates independently from the Medicaid agency or subject hospital may be qualified to perform the DSH audit.

Generally Accepted Government Auditing Standards are the principles governing audits conducted of government organizations, programs activities, functions or funds. In general, government audits are either performance audits or financial audits. In either type, the focus is on the government entity, its management of a program and/or the financial management and reporting systems associated with that program.

The DSH audit and report is a necessary part of the administration of the Medicaid program. The purpose of the audit is to ensure that States make DSH payments under their Medicaid program that are in compliance with Section 1923 of the Act. The audit does not encompass the review of the State's overall Medicaid program, it simply ensures that one portion of the program is conducted in line with Federal statutory limits. In addition, the DSH audit will rely on financial and cost report data provided by hospitals that are subject to generally accepted accounting principles as part of their primary reporting function.

Comment: Many commenters's expressed concern for the financial stability of disproportionate share hospitals and States and their requirement for finality, with respect to prior year DSH payment determinations. They asserted that allowing States to make good-faith efforts to estimate hospital-specific DSH payment limits, so long as States are using the most recently available data, would help prevent situations in which States would need to attempt to take back past DSH payments to hospitals--a situation that would be especially burdensome for the very kinds of hospitals that DSH payments are intended to help. One commenter stated that the new rules impose an extremely heavy penalty on certain small hospitals. That commenter indicated that it would be unlikely that these hospitals could repay any amounts to the Medicaid program from current operating income.

Response: We recognize that States must use estimates to determine DSH payments in a given year. The regulation will provide information that will help ensure that the actual DSH payment made by States based on those estimates do not exceed the actual eligible uncompensated costs under the hospital-specific DSH limit. The transition period included in this regulation ensures that States will have time to adjust those estimates prospectively.

Comment: Numerous commenter's did not see how the verification requirement could be completed without an additional annual cost report for an annual period that differs from its established fiscal year cost reporting period and an additional audit that would tie the hospital costs to the State year-end versus hospital year end and DSH payments with the same year actual uncompensated care costs. They asserted that the verification requirement is an extraordinary unreasonable and completely unnecessary administrative and economic burden on hospitals and States due to time-consuming, costly, and often duplicative audits. Many critical access hospitals do not have the excess manpower and resources to accomplish this additional audit. In many States, it disturbs an effective and efficient system that already meets Federal standards for program integrity.

Response: The DSH audit will rely on existing financial and cost reporting tools currently used by all hospitals participating in the Medicare program. We expect that State reports and audits will be based on the best available information. If audited Medicare cost reports are not available for each hospital, the DSH report and audit may need to be based on Medicare cost reports as filed. CMS does not believe that the audit data burden will be significant since the audit relies on documents already available to hospitals.

Comment: Many commenters's noted that it would be an administrative burden to perform retrospective reviews and adjust each year's DSH payments. Therefore, the commenter's request that CMS audit the data used by the State to determine the prospective DSH payments paid during the State fiscal year based upon the CMS approved DSH State plan payment methodology to determine the actual uncompensated care costs in the same audited SFY.

Response: Section 1923(j) of the Act imposes audit and reporting requirements on all States that make DSH payments to all DSH eligible hospitals within the State. As part of this process, CMS must determine if all hospitals receiving DSH payments under the Medicaid State plan actually qualify to receive such payments and that actual DSH payments made do not exceed the hospital-specific DSH limit for the same period.

DSH payments are limited by Federal law to each qualifying hospital's specific eligible uncompensated care cost in a given year. Auditing a State's DSH payment methodology will not ensure that DSH payments actually made by States do not exceed the statutorily required hospital-specific DSH limit. Verifying cost elements within a DSH payment methodology would not allow CMS to carry out the intent of the law which was to ensure that each DSH hospital will not exceed its hospital-specific DSH limit.

Comment: One commenter said Verification 3 would be a burden on the State. Another commenter stated that the requirements in Verification 3 would dictate significant additional work by the independent auditor (and added cost to the State and Federal governments) for unnecessary data analysis.

Response: CMS does not believe that Verification 3 in the regulation will create significant additional work for the independent auditor or the States. The auditor engaged by a State to complete the DSH audit must rely on information provided by the State and DSH hospitals. This information will be based on existing financial and cost reporting tools as well as information provided by the State's Medicaid Management Information System and the existing approved Medicaid State plan. DSH hospitals must provide the State with hospital-specific cost and revenue data, including backup documentation, so that independent auditor may utilize in developing audit report. The State must provide the auditor with information pertaining to the Medicaid State plan DSH payment methodologies and the methodology utilized by the State uses to estimate the hospital-specific DSH limits.

CMS has developed a General DSH Audit and Reporting Protocol to provide guidance to States, DSH hospitals and auditors in the completion of the DSH audit. This Protocol includes general instructions regarding the types of information to be provided by hospitals to the State and its auditor as well as the calculations the auditor will make based on the data provided. The Protocol will be available on the CMS Web site.

The DSH audit and report is a necessary element in the administration of the Medicaid program. The cost of the audit is the responsibility of the State and can be matched by the Federal government as a Medicaid administrative cost of the State.

Comment: One commenter questioned whether it is CMS' intent that the term ``appropriate'' indicates documentation that has been verified and/or audited. The vagueness of the term may also make it difficult for an independent auditor to provide an opinion. As an alternative, and assuming that all other requirements will be clearly defined, the commenter recommends that CMS consider an alternative that a State employs a methodology for calculating the hospital-specific DSH limit that is permissible under Federal rules.

Response: The statutory process requires examination of whether all hospitals receiving DSH payments under the Medicaid State plan actually qualify to receive such payments and whether actual DSH payments made are within the hospital-specific DSH limit for the same period. DSH payments are limited by Federal law to each qualifying hospital's specific eligible uncompensated care cost limit. Several audits by the Inspector General have highlighted the need for greater scrutiny and have indicated that calculations performed by State agencies or hospitals are not reliable.

Concerning the degree of data verification required, States and auditors will need to obtain data from hospitals and may need to work with hospitals to develop new data or methodologies to allocate or adjust existing data. And it may be necessary for auditors to develop methods to test, verify the accuracy of, and reconcile data from different sources. This audit function is not the same as the function of the hospital's own auditors, however, and would not involve a review of the hospital's financial controls and internal reporting procedures. But the auditors must review the overall methodology for accumulating data to ensure that the resulting data reflects the required elements. In other words, the independent auditors must review the methodology for arriving at hospital-specific data, and must have confidence that the data accurately represents the hospital's eligible uncompensated care costs consistent with the statutory criteria.

Comment: A few commenter’s are concerned that the reporting requirements, as stated in the proposed regulation, suggest that there is only one way to calculate DSH payments and hospital-specific DSH payment limits when, in reality, Federal guidelines give States some leeway in making these calculations. The commenter’s are concerned that auditors will interpret their mandate very literally. One commenter said the State may find itself disagreeing with its auditor over the definitions of certain requirements and methodologies. Without additional CMS clarification, the auditor may revert to a reasonableness test when clarification is lacking, which may not meet the objectives of CMS in promulgating these rules.

Response: We agree that States may have some flexibility in interpreting the payment provisions under their State plan, and we expect that auditors will consult with the State agency on such interpretative issues. The calculation of the hospital-specific limits is less discretionary; DSH payments are limited by Federal law to each qualifying hospital's specific uncompensated care costs incurred in furnishing hospital services to the Medicaid and uninsured populations.

Comment: A few commenters’s said this rule would adversely affect access to health care for all children, not just Medicaid beneficiaries. Hospitals may be forced to close programs or clinics in order to cover revenue losses and access to care for all children, not just Medicaid beneficiaries would be limited. Children and their families would be forced to seek care in emergency rooms, which is a more expensive visit for Medicaid and will invariably result in ever more crowded emergency rooms.

Response: DSH payments are a way to provide additional funding to hospitals that serve a disproportionate share of low income patients, but the statute limits DSH payments to each hospital to the total uncompensated care costs in serving the Medicaid and uninsured populations. Since these limitations have been in place since 1993, CMS does not believe that any hospital could reasonably have relied on receiving funding above that level. CMS recognizes that States must use estimates to determine DSH payments in a given year. The information available through the reporting and auditing program under this regulation will assist States in ensuring that those estimates do not generate DSH payments that exceed the hospital-specific DSH limit.

Comment: One commenter believes the independent audit requirements should be included in the existing framework for audits of Federal programs under the Single Audit Act and include the five items requiring verification in the OMB Circular A-133 Compliance Supplement. One commenter suggested revision of OMB Circular A-133 Compliance Supplement to require the State Medicaid program's auditor test this reporting requirement by ensuring the Medicaid program received the information and audit assurances from the hospitals, accumulated the information, and properly reported the results to the Centers for Medicare and Medicaid Services.

Response: The DSH audit and report is a necessary element in the administration of the Medicaid program. The purpose of the audit is to ensure that States make DSH payments under their Medicaid program that are in compliance with Section 1923 of the Social Security Act. DSH payments are a small portion of a State's Medicaid program and the OMB Circular A-133 direction is far larger in scope than this audit.

It would be inappropriate to make the requested revisions to OMB Circular A-133 as OMB Circular A-133 specifically exempts Medicaid payments made by the State because these Medicaid payments are not considered to be ``federal awards expended under this Section [Section 205, Basis for Determining Federal Awards Expended]''. In addition, Subpart E also indicates that the scope of the A-133 Audit shall cover the entire operations of the auditee or a department, agency or other organizational unit.

It should be noted that the Single State Audit Agency qualifies as operating independently from the Medicaid Agency and, therefore, could perform the DSH audit albeit separate from the Single State Audit Act.

Comment: One commenter requests confirmation that the audit would be a Program Performance Audit of the State as defined in Government Auditing Standards, July 1999, Chapter 2, and as such would not require verification by a Certified Public Accounting firm as in the case of financial audits that lead to the expression of an opinion as defined in Chapter 3. One commenter noted that requiring the audits of the States to be performed under Generally Accepted Government Auditing Standards (GAGAS) will ensure that the reports are accurate and can be relied upon by third party users. One commenter stated that there are three sets of standards within GAGAS: Financial Audits, Attestation Engagements, and Performance Audits and questioned which set of standards would apply to the independent audit of DSH payments.

Response: The standards in GAGAS generally exceed the scope and objectives of the DSH audit and report. GAGAS rules govern the audits of government organizations, programs activities, functions or funds. In general, government audits are either performance audits, attestation engagements or financial audits.

In financial and performance audits, the focus is on the government entity, its management of a program and/or the financial management and reporting systems associated with that program. The DSH audit and report is a review of a segment of the Medicaid program and therefore does not fall within the scope of a performance or financial audit under GAGAS rules.

Attestation engagements may take a narrower focus (less than full program review) and, therefore, may seem to more directly fit with the scope of the DSH audit and report. However, attestation agreements under GAGAS rules include standards beyond non-governmental attestation agreements and these additional standards exceed the scope of the DSH audit and report.

The DSH audit and report is a necessary part of the administration of the Medicaid program. The purpose of the audit is to ensure that States make DSH payments under their Medicaid program that are in compliance with Section 1923 of the Social Security Act. The audit does not encompass the review of the State's Medicaid program, it simply ensures that one portion of the program is conducted in compliance with Federal statutory limits. In addition, the DSH audit will rely on financial and cost report data provided by hospitals that are subject to generally accepted accounting principles as part of their primary reporting function.

4. Section 1115 Demonstrations

Comment: One commenter believes the proposed rule as presently drafted will have a significant impact on hospitals if an exemption is not provided. The State has operated its DSH program for a number of years in strict accordance with the prescriptive terms negotiated between the State and CMS.

Response: The MMA imposes audit and reporting requirements on all States that make DSH payments. As part of this process, CMS must determine if all hospitals receiving DSH payments under the Medicaid State plan actually qualify to receive such payments and that actual DSH payments do not exceed the hospital-specific DHS limit for that same period. To the extent that a State makes DSH payments under a waiver demonstration, the State is not exempted from the rules surrounding DSH payments, particularly those at 1923(g) of the Act, and the audit and reporting requirements would still apply to that State.

Comment: Several commenters's had questions regarding how States that operate their Medicaid programs under Federal waivers would do their Medicaid DSH reporting. The commenter's suggest the regulation should specify that the DSH reporting and audit requirements do not apply to States that do not make DSH payments or are not required to comply with DSH requirements pursuant to Federal waivers of DSH requirements. The commenter's urge CMS to exempt States with 1115 waivers from this rule if the waivers are based on certified public expenditures (Capes) for Medicaid and DSH payments. One commenter stated that the recent implementation of the State's 1115 waiver completely changes the way DSH payments are calculated for the State's hospitals, therefore, this audit requirement would be duplicative.

Response: These DSH audit and reporting requirements apply to States with Section 1115 demonstrations to the extent that the waiver list associated with the demonstration does not explicitly waive the State from compliance with Section 1923 of the Act. The DSH audit and reporting time frames for States with DSH programs and Section 1115 demonstrations are subject to the same time frames as those States without 1115 demonstrations. The only exception would be if a State has a demonstration project under Section 1115 that includes a waiver of the requirements of Section 1923 so that the State does not make Medicaid DSH payments at all. In that instance, since there are no DSH payments, the DSH audit and reporting requirements would not apply.

5. Time Period Subject to DSH Audit and Report

Comment: One commenter asked for clarification of the treatment of DSH payments when a State makes a portion of the fiscal year's DSH payments after the end of its fiscal year. One commenter asked whether, when DSH payments are made on an accrual accounting basis and adjusted after the report has been filed, whether the State must file a corrected report. Several commenters's indicated that dissatisfied hospitals have the ability to appeal their payments, a process that could extend the period of time before the final payment is known. They asked how to report regular Medicaid rate payments that are not known at the end of any given State fiscal year. One commenter said that many States allow Medicaid providers up to a year to submit claims following the date of service. As such, the commenter indicated that there is often a significant lag in payments to Medicaid hospitals and uncompensated care figures would be overstated if only cost incurred and payments received during a SFY are considered.

Response: Since the deadline for reporting the audit findings has been extended to at least three full years after the close of the Medicaid State plan rate year subject to audit, hospitals would have received all Medicaid and DSH payments associated with that Medicaid State plan rate year. This two-year period accommodates the one-year concern expressed in many comments regarding claim lags and is consistent with the varying hospital cost reporting periods and adjustments and accommodates DSH payments made from different allotment years.

It should be noted that, to the extent that a State makes a retroactive adjustment to non-DSH payments after the completion of the audit for that particular Medicaid State plan rate year, the hospital would necessarily have received and booked the revenues in a subsequent Medicaid State plan rate year. Under these circumstances, the revenue adjustments would be measured during the audit of the Medicaid State plan rate year in which the revenues were received.

The treatment of post-audit Medicaid payments, including regular Medicaid rate payments, supplemental and enhanced payments, Medicaid managed care payments, DSH, and ``self-pay'' revenues and other collections including liens would be treated as revenues applicable to the Medicaid State plan rate year in which they are received.

Comment: Several commenters's noted that the State is required to indicate the Medicaid Managed Care Organization Payments paid to the hospital for the SFY being reported. Claims may be submitted to the Medicaid Managed Care Organization (MCO) for payment up to one year after the date of service. Therefore, payments made by the MCO for claims with date of service in the SFY may be submitted up to a year after the service date by the hospital. The payments would not be available before 12 months after the SFY at a minimum. Obtaining the amount paid by the MCO for the SFY being reported is not possible by the end of the SFY.

Response: Based on the modifications to the audit and reporting deadlines and the Medicaid two-year timely filing claim limit, there should not be a significant adjustment to Medicaid payments that would warrant a corrected report. To the extent that such an adjustment to Medicaid payments occurs, no corrected audit or report is necessary. To the extent that a State makes a retroactive adjustment to non-DSH payments after the completion of the audit for that particular Medicaid State plan rate year, the hospital would necessarily have received and booked the revenues in a subsequent Medicaid State plan rate year. Under these circumstances, the revenue adjustments would be measured during the audit of the Medicaid State plan rate year in which the revenues were received.

6. Verification I--Proper Reduction to Uncompensated Care Cost

Comment: Several commenter's believe that different parts of the regulation define ``uncompensated care costs'' differently, and they should be modified and made consistent. The commenter's provided suggested changes in an effort to eliminate a contradiction between the definitions, contained in Sec. Sec. 447.299(c)(15) and 455.204(c). Several commenters' believe that Verification 1 requires each hospital receiving DSH payments reduce its uncompensated care costs by the amount of DSH payments received in any given year. The commenter's argued that the statute clearly defines the DSH limit so that DSH payments should not be offset against the hospital specific limits. They noted that the language of Section 1923(j) only requires the auditors to verify ```the extent to which'' the costs have been reduced. Thus, if costs have not been reduced at all, the auditor would verify that fact and the audit requirement would be met. The regulatory language should be revised to be consistent with the statutory requirement. Other commenter's stated that the proposed rule requires audit verification that each disproportionate share hospital in the State has reduced its uncompensated care costs in order to reflect the total amount of claimed DSH expenditures. They are not clear how a hospital can demonstrate this, as costs generally are not reduced by expenditures. One commenter recognizes that CMS likely based its formulation of the verification requirement on the statutory language, which contains similarly confusing terminology, requiring the audit 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 [the Medicaid DSH statute].'' The commenter suggests that a more useful interpretation of this statutory language would be to require verification that DSH payments have not exceeded uncompensated care costs.

Response: The purpose of the statute is for States to audit actual DSH payments made under the approved Medicaid State plan against actual eligible uncompensated hospital costs for the same time period. In reviewing the meaning of the statutory language, we have determined that verification 1 is designed to ensure that hospitals are able to fully retain the DSH payments made to them for the uncompensated cost of providing inpatient and outpatient hospital services to Medicaid beneficiaries and individuals with no source of third party coverage net of all Medicaid payments received and payments by or on behalf of individuals with no source of third party coverage for the services they received. We have revised the regulation text to make this clearer.

7. Verification 2--Calculation of Eligible Uncompensated Care Cost, Prospective Estimates versus Reconciled Cost

Comment: Many commenter's indicated that for States that determine the individual hospital DSH limit prospectively, the one-year filing requirement may be attainable (at least after these rules take effect) if the requirement is only to validate the accuracy of the prospective calculation. But for those States that do base the determination on current year costs, a report based on a final audit of hospital cost reports could not be submitted within one year. Final settlement of hospitals' cost reports is typically contingent upon completion by a Medicare intermediary of audits--a process that can take several years. CMS should allow these States additional time to submit the audit certifications, so these certifications can be based on the final settled cost report. Alternatively, CMS could clarify the rule to permit the required report to be based on a hospital's as-filed cost report. If necessary, there could be later reconciling adjustment after the cost report is finally settled and an audit certification can be made.

Response: CMS recognizes that States may need to use estimates to determine DSH payments made by States to individual qualifying hospitals in an upcoming Medicaid State plan rate year. Section 1923(j) of the Act requires States to report and audit hospital-specific DSH payments and hospital-specific uncompensated care costs. To meet this requirement, States must perform audits associated with defined periods of time and must identify the actual costs incurred and payments received during that defined time period. To respond to comments on the practicality of audit timing, we have modified the time frame for the audit and reporting requirements as discussed above. We also note that we expect that reports and audits will be based on the best available information. If audited Medicare cost reports are not available, the DSH report and audit may need to be based on Medicare cost reports as filed.

Comment: Numerous States indicated that if the audit requirement is simply to verify the manner in which the DSH limit was applied prospectively, the one-year timeline may be realistic for years subsequent to the adoption of a final regulation for States using prospective methods, and hospitals with fiscal years different than the State's should not present as much of a concern, because the prospectively determined limit would have been calculated based on cost reports for earlier time periods. Accordingly, the commenter's request that CMS clarify that the proposed regulations are not intended to disturb the use of prospective calculations to apply the individual hospital DSH limit.

Response: This regulation is not intended to require States to implement retrospective DSH methodologies. CMS recognizes that States may need to use estimates to determine DSH payments in an upcoming Medicaid State plan rate year. However, Section 1923(j) of the Act requires confirmation that DSH payments made by States to individual qualifying hospitals do not exceed the actual cost limitation imposed by Congress.

Based on the revisions to the auditing and reporting timeframes, which, in part, requires the Medicaid State Plan rate year 2005 and 2006 audits to be completed no later than the last day of Federal fiscal year 2009, it is feasible for the audit to measure eligible uncompensated care costs incurred against the DSH payments received in a given time frame. The transition period included in the final regulation ensures that States may adjust those estimates prospectively to avoid any immediate adverse fiscal impact and to ensure that future DSH payments do not exceed the hospital-specific DSH limits.

Comment: Several commenters's noted that there is no current law requiring that DSH payments made in a fiscal year correspond to costs from that same fiscal year. In addition, CMS has never before imposed a reconciliation requirement. A few commenters's stated Section 1923(g) of the Act does not require that the OBRA 1993 limits be recalculated and reapplied to reflect subsequently available year-of-service data.

Response: Section 1923(j) of the Act requires States to report and audit specific payments and specific costs. These reports must assess compliance with the statutory hospital-specific limitations on the level of DSH payments to which qualifying hospitals were entitled. Section 1923(g)(1)(A) specifies that DSH payments cannot exceed, ``the costs incurred during the year of furnishing hospital services (as determined by the Secretary and net of payments under this title, other than under this Section, and by uninsured patients * * *)''. The goal of the regulation is to audit DSH payments made under the authority of the Medicaid State plan and to ensure that States do not make DSH payments that exceed the hospital-specific cost limit defined under the Omnibus Budget Reconciliation Act of 1993.

CMS recognizes that States may need to use estimates to determine DSH payments in an upcoming Medicaid State plan rate year. However, the statute requires confirmation that DSH payments do not exceed the actual cost limitation imposed by Congress.

Comment: Numerous commenters's stated that the DSH reporting and auditing requirements contained in MMA were intended only to ensure compliance with the DSH requirements, not to change the DSH requirements themselves. They asserted that nothing in the statute either requires or encourages a change in CMS's longstanding policy that DSH payments can be based on a prospective estimate of a hospital's uncompensated care costs. They argued that the statute does not require that payments be based on actual audited costs and nothing in the statute requires CMS to impose this dramatic shift in policy. This approach allows for adjustment during future years for reconciling DSH payments to actual costs. Numerous commenter's said that CMS has always acknowledged that the law permits States to base their DSH payments on a prospective estimate of a hospital's uncompensated care costs for a given year, derived from the hospital's costs in prior years, and many if not most States utilize this approach. A few commenter's noted that CMS has allowed States flexibility to use estimates of current year uncompensated costs. One commenter stated the statute provides that a DSH payment adjustment ``during a fiscal year'' is considered non-compliant with the limit if the adjustment exceeds the uncompensated costs for Medicaid and uninsured patients incurred ``during the year'' and that CMS appears to be basing this burdensome reconciliation requirement solely on this language. The commenter believes that while the provision does limit current year payments to current year costs, nothing in the language mandates the use of actual audited costs. Indeed, the commenter indicated that reliable estimates based on audited prior year data will produce sufficient controls on the DSH payments and fulfill Congress' intent of limiting DSH expenditures on a hospital-specific basis.

Response: Section 1923(g)(1)(A) of the Act specifies that DSH payments cannot exceed, ``the costs incurred during the year of furnishing hospital services (as determined by the Secretary and net of payments under this title, other than under this Section, and by uninsured patients * * *)''. The goal of the regulation is to audit DSH payments made under the authority of the Medicaid State plan and to ensure that States do not make DSH payments that exceed the hospital-specific cost limit defined under the Omnibus Budget Reconciliation Act of 1993.

Section 1923(j) of the Act expressly requires States to report and audit specific payments and specific costs. As part of this process, CMS must obtain all information necessary to determine if all hospitals receiving DSH payments under the authority of the approved Medicaid State plan actually qualify to receive such payments and that actual DSH payments made by States do not exceed the hospital-specific limit for the same period. DSH payments are limited by Federal law to each qualifying hospital's specific eligible uncompensated care cost limit.

CMS recognizes that States may need to use estimates to determine DSH payments in an upcoming Medicaid State plan rate year. However, the statute requires confirmation that DSH payments do not exceed the actual cost limitation imposed by Congress. CMS has modified the regulation to include a transition period to ensure that States may adjust those estimates prospectively to avoid any immediate adverse fiscal impact and to ensure that future DSH payments do not exceed the hospital-specific DSH limits.

Auditing actual payments made in a given year against estimated hospital uncompensated care costs in that same year would not ensure that DSH payments did not exceed actual uncompensated care costs. Several Inspector General audits attest to the discrepancies in the results. In fact, measuring the difference between DSH payments and estimates of uncompensated care costs would never produce a true determination of whether or not DSH payments in a given year exceeded the congressionally defined cost limit for that year.

Comment: Numerous commenter's indicated that States cannot determine the actual uncompensated care costs prior to or during the year that DSH payments are made. The commenter's stated that this could prevent States from making prospective estimates of Medicaid shortfalls and uninsured costs. The commenter's recommend that States be allowed to continue to utilize historical information to perform prospective DSH limit calculations.

Response: CMS recognizes that States may need to use estimates to determine DSH payments in an upcoming Medicaid State plan rate year. However, CMS does not have authority to authorize payments that exceed statutory hospital-specific limits and those limits are based on actual uncompensated care costs. The goal of the regulation is to audit DSH payments made under the authority of the Medicaid State plan and to ensure that States do not make DSH payments that exceed those statutory hospital-specific cost limits. The information necessary for such confirmation is readily available to hospitals and the State based on existing financial and cost reporting tools.

Comment: Many commenters's noted that the proposed methodology would be inconsistent with their approved Medicaid State plan and conflicts with past CMS guidance and practice. They indicate that a retrospective audit to determine the accuracy of the estimates used to determine uncompensated care costs based on the approved prospective methodology would require changing the State plan. They ask how this audit should be conducted by States that already have CMS approval for use of prospective methodologies, not to mention that a retroactive audit could significantly affect already approved programs.

Response: This regulation is not intended to require States to implement retrospective DSH methodologies. CMS recognizes that States may need to use estimates to determine DSH payments in an upcoming Medicaid State plan rate year. However, CMS cannot authorize DSH payments that exceed the limitations imposed by Congress. States will have to determine how to best ensure that prospective DSH methodologies do not result in payments that exceed those limitations, either by revising those methodologies or by providing for reconciliation of prospective payments with those limits. CMS as always is available to offer technical assistance to States in developing such methodologies.

CMS has modified the regulation to include a transition period to ensure that States may adjust prospective estimates to avoid any immediate adverse fiscal impact.

8. Fiscal Impact--Effect on Federal Financial Participation

Comment: A few commenters's questioned whether CMS will withhold Federal Financial Participation from the States until its Independent Audit of DSH Payments is completed and filed with CMS.

Response: The final regulation defines the time periods applicable to the auditing and reporting of DSH payments. These deadlines provide sufficient time for States to comply with the statute. The final regulation also provides that Federal financial participation for DSH payments is not available to any State that has not submitted its required audits and reports.

Comment: A few commenters's said that the proposed regulation states the penalty for failure to provide the required information by the stipulated deadline but does not address the question of whether or not CMS will require States to return DSH funds if the information collected is unsatisfactory to CMS.

Response: The goal of the regulation is to audit DSH payments made under the authority of the Medicaid State plan and to ensure that States do not make DSH payments that exceed the hospital-specific cost limit defined in Section 1923(g) of the Act. CMS has modified the regulation to include a transition period to ensure that States have an opportunity to refine audit and reporting practices and determine the impact on the State DSH methodologies. The final regulation provides that Federal financial participation for DSH payments is not available to any State that has not submitted its required audits and reports. However, CMS intends to work with States to ensure that the audits and reports meet all statutory and regulatory requirements.

Comment: A few commenters's asked for clarification on the actions that may be taken against States if States are not found to be in compliance with all verifications required as part of the audit (Sec. 455.204(c)).

Response: The final regulation defines the time periods applicable to the auditing and reporting of DSH payments. These deadlines provide sufficient time for States to comply with the statute. The final regulation also provides that Federal financial participation in DSH payments is not available to any State that has not submitted its required audits and reports. As mentioned above, CMS intends to work with States to ensure that the audits and reports meet all statutory and regulatory requirements.

Comment: A few commenters's said the proposed regulation is silent on the question of post-audit adjustments. In some cases, audits will reveal actual costs that were not included in the estimated uncompensated care costs provided. In such cases, provided there are funds remaining in the State's DSH allotment or other money available for such purposes, the commenter's recommended that States should be permitted to compensate hospitals.

Response: CMS has modified the regulation to lengthen the time frame for preparation of the required report and audit, and to include a transition period to ensure that States have time to refine their audit processes. The instance of post audit adjustments will be significantly lessened as a result.

9. Verification Three--Data Sources Used in Calculation of Eligible Uncompensated Care Costs

Comment: Many commenters's requested clarity on the mechanics of reconciliation. Although the MMA requires an annual certified public audit, the proposed rule is unclear about how the audit will reconcile DSH payments and the hospitals' calculation of actual compensated care. Hospitals submit accurate data on Medicaid and uncompensated care at a point in time. Data can change over time as claims and payment appeals are settled.

Response: We believe that the three-year period allotted for completion of the audit accommodates these concerns. Sufficient time is available to ensure that necessary cost reports and other financial data are available to make these determinations. This accommodates the concern expressed in many comments regarding claims lags and is consistent with the varying hospital cost report periods and adjustments. CMS has developed a General DSH Audit and Reporting Protocol to provide guidance to States, DSH hospitals and auditors in the completion of the DSH audit. This protocol provides general instructions regarding the calculations the auditor will make based on the data provided.

10. Verification Four--Proper Accounting of Medicaid and Uninsured Revenues

Comment: A few commenters's noted that the audit and reporting requirements are unnecessary in several States where the federal DSH allocation to the States has consistently fallen short of the State's aggregate DSH limit by at least $200 million in each of the past five years.

Response: The Statewide aggregate DSH allotment is only one of the limitations on DSH payments. The audit and reporting requirements also concern hospital-specific limitations, which involve review of specific payments and specific costs by individual hospital. The goal of the audit and report is to ensure that DSH payments made by States under the authority of the approved Medicaid State plan do not exceed the hospital-specific uncompensated care cost limit as required by Section 1923(g) of the Act. Irrespective of a State's aggregate DSH allotment, or overall levels of uncompensated care, a DSH hospital may not receive more in DSH payments than the individual hospital's eligible uncompensated care costs.

Comment: A few commenters's stated that the financial exposure for the Federal government through the use of estimated rather than reconciled data is not significant, as total DSH expenditures are limited by the Statewide DSH allotment. The benefit obtained through the reconciliation mandate is therefore far outweighed by its costs.

Response: As discussed above, the Statewide DSH allotment and hospital-specific limitations are separate and distinct. Section 1923(g)(1)(A) of the Act specifies that DSH payments cannot exceed, ``the costs incurred during the year of furnishing hospital services (as determined by the Secretary and net of payments under this title, other than under this Section, and by uninsured patients * * *)''. Section 1923(j) of the Act and this regulation require States to audit DSH payments made under the authority of the Medicaid State plan and to ensure that States do not make DSH payments that exceed this hospital-specific cost limit.

The data elements necessary for the State to complete the DSH audit and report should, in part, be information the State already gathers to administer the DSH program. Thus, CMS believes that the burden on the State will not be substantial. The State will have some additional cost associated with engaging an auditor but that cost is eligible for Federal administrative matching funds.

Comment: Numerous commenters's expressed concern about the proposed rule because adoption would greatly reduce the DSH payments to hospitals. Such a reduction would eliminate some of the future services hospitals provide. The largest burden would be on the impoverished communities since many of those people could not travel to receive those services elsewhere.

Response: Hospitals should not realize a significant reduction in DSH payments based on the audit and reporting requirements. Moreover, any reduction would simply be the result of ensuring that limited State DSH funds are used appropriately and meet the requirements of the Medicaid statute. This rule will help to ensure that Medicaid DSH payments appropriately recognize allowable unreimbursed Medicaid and uninsured uncompensated care costs. The DSH law was enacted to recognize needs of hospitals that serve a disproportionate number of Medicaid and low-income patients. In 1993, Congress imposed hospital-specific limitations on the level of DSH payments to which qualifying hospitals were entitled. Section 1923(g)(1)(A) specifies that DSH payments cannot exceed, ``the costs incurred during the year of furnishing hospital services (as determined by the Secretary and net of payments under this title, other than under this Section, and by uninsured patients * * *)''. Congress clearly identified the DSH limit as specific to the costs incurred for providing certain hospital services to Medicaid individuals and individuals with no source of third party coverage.

Comment: Several commenters's expressed concern that the results of audits may be used to attempt to take back money from States and/or hospitals for failing to meet standards that they never knew existed, long after hospital's fiscal year is over. If the State would be required to return DSH money to the Federal Government, this would necessitate the return of DSH money to the State by hospitals. This would be extremely burdensome for hospitals, which undoubtedly would already have spent that money serving their low-income and uninsured patients. One commenter said that after-the-fact exposure is untenable for States with balanced budget requirements.

Response: CMS has modified the regulation to include a transition period to ensure that States may adjust uncompensated care estimates prospectively to avoid any immediate adverse fiscal impact and to assist States in ensuring that future DSH payments do not exceed the hospital-specific DSH limit. To permit States an opportunity to develop and refine audit procedures, audit findings from Medicaid State plan rate year 2005-2010 will be limited to use for the purpose of estimating prospective hospital-specific uncompensated care cost limits in order to make actual DSH payments in the upcoming Medicaid State plan rate years. CMS is not requiring retroactive collection for Medicaid State plan rate years that have already passed. By using that time to improve State DSH payment methodologies, States may avoid circumstances in which DSH payments that exceed Federal statutory limits must be recouped from hospitals. CMS will also be available to provide necessary technical assistance to States to ensure proper implementation of these requirements.

Comment: One commenter said that their State plan permitted DSH payments to DSH-eligible, out-of-State hospitals that service the State's Medicaid recipients. The commenter requested clarity regarding the State's responsibility in terms of hospital-specific DSH limit calculations and auditing and reporting requirements insofar as these out-of-State hospitals are concerned.

Response: A State is required to audit payments and costs for only those DSH hospitals that are located within the State. This method will allow the auditor to recognize DSH payments received from other States in addition to the DSH payments received by that hospital under the ``home-State's'' approved Medicaid State plan.

For States that make DSH payments to hospitals in other States, the State must include in the reporting requirements the DSH payments made to hospitals located outside of the State but would not be required to audit those out-of-State DSH hospital's total DSH payments/total eligible uncompensated care costs. This method will ensure that no DSH hospital is audited more than one time per year for purposes of the DSH auditing and reporting requirements under Section 1923(j) of the Act.

Comment: A few commenters's asked whether CMS will require States to include in the report information on patients from another State.

Response: The goal of the audit and report is to ensure that DSH payments made by States under the authority of the approved Medicaid State plan do not exceed the hospital-specific cost limit. In order to do this, all applicable revenues must be offset against all eligible costs. For purposes of determining the hospital-specific DSH limit, revenues would include all Medicaid payments made to hospitals for providing inpatient and outpatient hospital services to Medicaid individuals (irrespective of the State in which the individual is eligible) and all payments made by or on behalf of patients with no source of third party coverage for the inpatient and outpatient hospital services they received. For purposes of the DSH audit and to determine whether hospital-specific cost limits have been exceeded, all DSH payments made by States and received by a hospital would need to be offset against the determined eligible uncompensated care cost limit.

Any Medicaid payments received by a hospital from any Medicaid agency (in state or out of state) should be counted as revenue offsets against total incurred Medicaid costs. Any DSH payments received by a hospital from any Medicaid agency (in state or out of state) must be counted as an offset against uncompensated care for purposes of the DSH audit and ensuring that the hospital-specific DSH limit is not exceeded.

Comment: One commenter requested instructions for reporting information to CMS related to DSH payments on an annual basis. Annual reporting requirements also contain specific reporting requirements related to DSH payments. The commenter asked for clarification as to whether the proposed rules supersede the reporting requirements detailed in the March 26, 2004, Federal Register Notice [CMS-2062-N].

Response: All DSH reporting requirements published under CMS-2062-N are superseded by Section 1923(j) of the Act and this implementing regulation.

Comment: A few commenters's noted the proposed Sec. 447.299(c)(8) incorrectly refers to Section 1923(g) instead of referring to the entire Section 1923.

Response: The regulation has been modified to reflect the correct statutory citation.

Comment: A few commenters's noted that the Reporting form was not included with the proposed rules and requested a copy of the example Reporting form.

Response: A modified Reporting form is included in this regulation.

Comment: One commenter noted that in FY 2003, total Federal DSH allotments to States totaled just under $9 billion. The commenter requests copies of any audit findings and/or programs associated with CMS' historic and ongoing efforts to audit and/or verify the figures used by States to justify Federal funds.

Response: The commenter may request information consistent with the authority of the Freedom of Information Act.

Comment: One commenter noted CMS has not pointed to any systematic findings that call into question the reasonableness of approved methodologies.

Response: The statutory authority under MMA instructed States to report and audit specific payments and specific costs. This rule does not call into question the reasonableness of approved methodologies; it simply implements the statutory reporting and auditing requirements to determine whether DSH payments were proper with respect to the specific DSH hospitals that were paid.

IV. Changes to the Proposed Rule

As explained in our responses to comments, we have made the following revisions to the DSH Auditing and Reporting regulations published in the August 26, 2005 Proposed Rule:

A. Reporting Requirements

1. Audit Year and Submission Dates Defined

CMS has modified the regulation at Sec. 447.299(c) to address concerns regarding the inability to complete the audit and report within a year from the end of SFY 2005. The regulation has been modified to identify the Medicaid State plan rate year 2005 as the first time period subject to the audit. The basis for this modification is recognition of varying fiscal periods between hospitals and States. The Medicaid State plan rate year is the one uniform time period under which all States must estimate uncompensated costs in order to make DSH payments under the approved Medicaid State plan. The regulation has also been modified to identify that each audit report must be submitted to CMS within 90 days of the completion of the independent certified audit. The reports associated with Medicaid State plan rate years 2005 and 2006 are due no later than December 31, 2009. Each subsequent audit report is due no later than December 31st of the FFY ending three years after the Medicaid State plan rate year under audit.

2. Report Data Elements

CMS has modified the regulation at Sec. 447.299(c) to address many comments concerning the necessary data elements to fulfill the audit and reporting requirements. Specifically, the regulation has been modified to remove the following data elements:

1. Medicare provider number.
2. Medicaid provider number.
3. Type of hospital.
4. Type of hospital ownership.
5. Transfers.
6. Medicaid eligible and uninsured individuals.

In addition, the regulation at Sec. 447.299(c) has been modified to add or clarify the following data elements which are necessary to fulfill the auditing and reporting requirements:

1. Identification of facilities that are Institutes for Mental Disease (IMD) receiving DSH payments;
2. Identification of out-of-state hospitals receiving DSH payments;
3. State estimate of hospital-specific DSH limit;
4. Medicaid inpatient utilization rate (if applicable);
5. Low-income utilization rate (if applicable);
6. State-defined DSH eligibility statistic (if applicable);
7. Total inpatient and outpatient Medicaid payments;

8. Total inpatient and outpatient Medicaid cost of care;
9. Total Medicaid inpatient and outpatient uncompensated care;
10. Total inpatient and outpatient uninsured and self-pay revenues;
11. Total applicable Section 1011 payments received by the hospital;
12. Total inpatient and outpatient uninsured cost of care;
13. Total inpatient and outpatient uninsured uncompensated care;
14. Total eligible inpatient and outpatient uncompensated care.

The Reporting form has also been modified to reflect these modifications.

B. Audit Requirements

1. Definitions

CMS has modified the regulation at Sec. 455.201 to clarify the definition of independent certified audit to mean that the Single State Audit Agency or any other CPE firm that operates independently from the Medicaid agency is eligible to perform the DSH audit and to define Medicaid State plan rate year as the time period subject to the audit. The definition of State fiscal year has been removed.

2. Certified Independent Audit Requirements

Based on many comments regarding the potential immediate adverse fiscal impact of the DSH audit on States, CMS has modified the regulation at Sec. 455.204(a) to indicate conditions related to the audit that States must meet in order to receive Federal disproportionate share hospital payments. A transition period related to audit findings for Medicaid State plan rate year 2005 through 2010 is included in this Section. Instructions regarding audit findings and their applicability to Medicaid State plan rate year 2011 forward are also included. The modifications are as follows:

Transition period. Findings of the 2005 and 2006 Medicaid State plan rate year audit and report will be available to States during their SFY 2010. These findings must be taken into consideration for Medicaid State plan rate year 2011 uncompensated care cost estimates and associated DSH payments.

Audit findings associated with Medicaid State plan rate years 2007 through 2010 must be similarly considered for Medicaid State plan rate years 2012 through 2015. Findings from Medicaid State plan rate year 2005-2010 will be used only for the purpose of determining prospective hospital-specific eligible uncompensated care cost limits and associated DSH payments.

DSH payments that exceed the hospital-specific eligible uncompensated care cost limit related to Medicaid State plan rate year 2011 must be returned to the Federal government or redistributed by States to other qualifying hospitals.

In response to many public comments regarding the inability of States to complete the audit within one year of the end of the State fiscal year, CMS has modified the regulation at Sec. 455.204(b) to indicate a new time period for the submission of the independent certified audit. The new time period is as follows:

Identify that the Medicaid State plan rate year 2005 and 2006 audits must be completed no later than the last day of Federal fiscal year 2009. Each subsequent audit beginning with Medicaid State plan rate year 2007 must be completed by the last day of the Federal fiscal year ending three years from the Medicaid State plan rate year under audit. Therefore, for the 2007 Medicaid State plan rate year, the audit must be completed by the last day of Federal fiscal year 2010.

The regulation was modified at 455.204(c) to include a new Section identifying the primary sources and source documents from which States will draw data necessary to complete the independent certified audit. These documents are identified as:

The approved Medicaid State plan for the State plan rate year under audit.

State Medicaid Management Information System payment and utilization data.

The Medicare 2552-96 cost report or subsequent Medicare defined hospital cost report tool.

DSH hospital audited financial statements and hospital accounting records.

The regulation was modified to redesignate Sec. 455.204(c) as Sec. 455.204(d) (1) through (6) to accommodate the new Sec. 455.204(c).

In addition, CMS developed a General DSH Auditing and Reporting Protocol to provide States with guidance on the completion of the DSH Audit and Report. This protocol will be available on the CMS Web site.

V. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 30-day notice in the Federal Register and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, Section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

The need for the information collection and its usefulness in carrying out the proper functions of our agency.

The accuracy of our estimate of the information collection burden.

The quality, utility, and clarity of the information to be collected.

Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

Therefore, we are soliciting public comment on each of these issues for the following information collection requirements discussed below.

Section 447.299 Reporting Requirements

Paragraph (c) of this Section requires the States to submit to CMS information for each DSH for the most recently-completed fiscal year beginning with the first full State fiscal year (SFY) after the enactment of Section 1001(d) of the MMA, which for all States will begin with their respective SFY 2005 and each subsequent SFY. This paragraph presents the information to be submitted.

The burden associated with this requirement is the time and effort for the States to prepare and submit the required information. We estimate that it will take each State approximately 30 minutes to prepare and submit the information for each of its DSHs. On average, each State has approximately 75 DSHs. Therefore, we estimate it will take 38 hours per State to comply for a total of 1,976 annual hours. The burden for this requirement is currently approved under OMB 0938-0746 with an expiration date of August 31, 2011.

Section 455.204 Condition for Federal Financial Participation

In summary, this Section states what information must be included in the audit report and submitted to CMS.

The PRA exempts the information collection activities referenced in this Section. In particular, 5 CFR 1320.4 excludes collection activities during the conduct of administrative actions, investigations, or audits involving an agency against specific individuals or entities.

As required by Section 3504(h) of the Paperwork Reduction Act of 1995, we have submitted a copy of this final regulation to OMB for its review of these information collection requirements described above.

If you comment on these information collection and recordkeeping requirements, please mail copies directly to the following:

Centers for Medicare & Medicaid Services, Office of Strategic Operations and Regulatory Affairs, Division of Regulations Development, Attn.: Melissa Musotto, CMS-2198-F, Room C5-14-03, 7500 Security Boulevard, Baltimore, MD 21244-1850.

Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503, Attn.: Katherine T. Astrich, CMS Desk Officer, CMS-2198-F, Katherine_T._Astrich@omb.eop.gov. Fax (202) 395-6974.

VI. Regulatory Impact Analysis

We have examined the impact of this rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96-354), Section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104-4), and Executive Order 13132 on Federalism, and the Congressional Review Act (5 U.S.C. 804(2)).

Executive Order 12866, as amended, directs agencies to asses all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year). This rule does not reach the economic threshold and thus is not considered a major rule.

The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations and government agencies. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $7 million to $34.5 million in any 1 year. Individuals and States are not included in the definition of a small entity. We are not preparing an analysis for the RFA because the Secretary has determined and we certify that this rule would not have a significant economic impact on a substantial number of small entities. This rule will directly affect States.

In addition, Section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of Section 604 of the RFA. For purposes of Section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a metropolitan statistical area and has fewer than 100 beds. Therefore, the Secretary has determined and we certify that this final rule will not have a significant impact on the operations of a substantial number of small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act (UMRA) of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2008 that threshold level is approximately $130 million. Since this rule would not mandate spending on State, local, or tribal governments in the aggregate, or by the private sector of $130 million or more in any 1 year, the requirements of the UMRA are not applicable.

Based upon the parameters of this rule and comments received, we do not believe the costs incurred by States will be significant. The final rule allows the DSH audits to be part of a hospital's annual financial audit (for example, the auditors would follow the DSH limit protocol provided in the regulation), which means a portion of the audit costs could actually be borne by the hospitals and not the States. Based upon comments received, it appears that most States want to incorporate the DSH audit into the annual hospital financial audits. If that is the case, the costs to the hospital should be minimal as well since the annual hospital financial audit is already a requirement.

It is further unknown if any States will contract with an independent accounting firm to conduct the audit. While there would be a contracting cost to the State, it is unknown what that cost would be and we believe it unlikely that States will avail themselves of this option. The final rule does allow for the use of the Single State Auditor to perform the DSH audit and if that is done, CMS would match the State audit costs at the 50 percent administrative matching rate.

Regardless of the mechanism for conducting the DSH audit, the auditor will be using existing documentation (for example, hospital cost reports, hospital accounting records, and MMIS) and apply the methodology provided by this rule, which should result in nominal costs.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs of State and local governments, preempts State law, or otherwise has Federalism implications. Since this rule would not impose any costs on State or local governments, preempt State law, or otherwise have Federalism implications, the requirements of E.O. 13132 are not applicable.

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

List of Subjects

42 CFR Part 447

Accounting, Administrative practice and procedure, Drugs, Grant programs--health, Health facilities, Health professions, Medicaid, Reporting and recordkeeping requirements, and Rural areas.

42 CFR Part 455

Fraud, Grant programs--health, Health facilities, Health professions, Investigations, Medicaid, and Reporting and recordkeeping requirements.

The Centers for Medicare & Medicaid Services amends 42 CFR chapter IV as follows:

PART 447--PAYMENTS FOR SERVICES

1. The authority citation for part 447 continues to read as follows:

Authority: Sec 1102 of the Social Security Act (42 U.S.C. 1302).

2. Section 447.299 is amended by--

A. Redesignating existing paragraphs (c) and (d) as paragraphs (d) and (e).

B. Adding a new paragraph (c) to read as set forth below.

Sec. 447.299 Reporting requirements.

* * * * *

(c) Beginning with each State's Medicaid State plan rate year 2005, for each Medicaid State plan rate year, the State must submit to CMS, at the same time as it submits the completed audit required under Sec. 455.204, the following information for each DSH hospital to which the State made a DSH payment in order to permit verification of the appropriateness of such payments:

(1) Hospital name. The name of the hospital that received a DSH payment from the State, identifying facilities that are institutes for mental disease (IMDs) and facilities that are located out-of-state.

(2) Estimate of hospital-specific DSH limit. The State's estimate of eligible uncompensated care for the hospital receiving a DSH payment for the year under audit based on the State's methodology for determining such limit.

(3) Medicaid inpatient utilization rate. The hospital's Medicaid inpatient utilization rate, as defined in Section 1923(b)(2) of the Act, if the State does not use alternative qualification criteria described in paragraph (c)(5) of this section.

(4) Low income utilization rate. The hospital's low income utilization rate, as defined in Section 1923(b)(3) of the Act if the State does not use alternative qualification criteria described in paragraph (c)(5) of this section.

(5) State defined DSH qualification criteria. If the State uses an alternate broader DSH qualification methodology as authorized in Section 1923(b)(4) of the Act, the value of the statistic and the methodology used to determine that statistic.

(6) IP/OP Medicaid fee-for-service (FFS) basic rate payments. The total annual amount paid to the hospital under the State plan, including Medicaid FFS rate adjustments, but not including DSH payments or supplemental/enhanced Medicaid payments, for inpatient and outpatient services furnished to Medicaid eligible individuals.

(7) IP/OP Medicaid managed care organization payments. The total annual amount paid to the hospital by Medicaid managed care organizations for inpatient hospital and outpatient hospital services furnished to Medicaid eligible individuals.

(8) Supplemental/enhanced Medicaid IP/OP payments. Indicate the total annual amount of supplemental/enhanced Medicaid payments made to the hospital under the State plan. These amounts do not include DSH payments, regular Medicaid FFS rate payments, and Medicaid managed care organization payments.

(9) Total Medicaid IP/OP Payments. Provide the total sum of items identified in Sec. 447.299(c)(6), (7) and (8).

(10) Total Cost of Care for Medicaid IP/OP Services. The total annual costs incurred by each hospital for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individuals.

(11) Total Medicaid Uncompensated Care. The total amount of uncompensated care attributable to Medicaid inpatient and outpatient services. The amount should be the result of subtracting the amount identified in Sec. 447.299(c)(9) from the amount identified in Sec. 447.299(c)(10). The uncompensated care costs of providing Medicaid physician services cannot be included in this amount.

(12) Uninsured IP/OP revenue. Total annual payments received by the hospital by or on behalf of individuals with no source of third party coverage for inpatient and outpatient hospital services they receive. This amount does not include payments made by a State or units of local government, for services furnished to indigent patients.

(13) Total Applicable Section 1011 Payments. Federal Section 1011 payments for uncompensated inpatient and outpatient hospital services provided to Section 1011 eligible aliens with no source of third party coverage for the inpatient and outpatient hospital services they receive.

(14) Total cost of IP/OP care for the uninsured. Indicate the total costs incurred for furnishing inpatient hospital and outpatient hospital services to individuals with no source of third party coverage for the hospital services they receive.

(15) Total uninsured IP/OP uncompensated care costs. Total annual amount of uncompensated IP/OP care for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individuals and to individuals with no source of third party coverage for the hospital services they receive. The amount should be the result of subtracting paragraphs (c)(12) and (c)(13), from paragraph (c)(14) of this section. The uncompensated care costs of providing physician services to the uninsured cannot be included in this amount. The uninsured uncompensated amount also cannot include amounts associated with unpaid co-pays or deductibles for individuals with third party coverage for the inpatient and/or outpatient hospital services they receive or any other unreimbursed costs associated with inpatient and/or outpatient hospital services provided to individuals with those services in their third party coverage benefit package. Nor does uncompensated care costs include bad debt or payer discounts related to services furnished to individuals who have health insurance or other third party payer.

(16) Total annual uncompensated care costs. The total annual uncompensated care cost equals the total cost of care for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individuals and to individuals with no source of third party coverage for the hospital services they receive less the sum of regular Medicaid FFS rate payments, Medicaid managed care organization payments, supplemental/enhanced Medicaid payments, uninsured revenues, and Section 1011 payments for inpatient and outpatient hospital services. This should equal the sum of paragraphs (c)(11) and (c)(15) subtracted from the sum of paragraphs (c)(9), (c)(12) and (c)(13) of this Section.

(17) Disproportionate share hospital payments. Indicate total annual payment adjustments made to the hospital under Section 1923 of the Act.

(18) States must report DSH payments made to all hospitals under the authority of the approved Medicaid State plan. This includes both in-State and out-of-State hospitals. For out-of-State hospitals, States must report, at a minimum, the information identified in Sec. 447.299(c)(1) through (c)(6), (c)(8), (c)(9) and (c)(17).

*** * * * ***

PART 455--PROGRAM INTEGRITY: MEDICAID

1. The authority citation for part 455 continues to read as follows:

Authority: Sec 1102 of the Social Security Act (42 U.S.C. 1302).

2. Add new subpart D to read as follows:

Subpart D--Independent Certified Audit of State Disproportionate Share Hospital Payment Adjustments

Sec.
455.300 Purpose.
455.301 Definitions.
455.304 Condition for Federal financial participation (FFP).

Subpart D--Independent Certified Audit of State Disproportionate Share Hospital Payment Adjustments

Sec. 455.300 Purpose.

This subpart implements Section 1923(j)(2) of the Act.

Sec. 455.301 Definitions.

For the purposes of this subpart--

Independent certified audit means an audit that is conducted by an auditor that operates independently from the Medicaid agency or subject hospitals and is eligible to perform the DSH audit. Certification means that the independent auditor engaged by the State reviews the criteria of the Federal audit regulation and completes the verification, calculations and report under the professional rules and generally accepted standards of audit practice. This certification would include a review of the State's audit protocol to ensure that the Federal regulation is satisfied, an opinion for each verification detailed in the regulation, and a determination of whether or not the State made DSH payments that exceeded any hospital's specific DSH limit in the Medicaid State plan rate year under audit. The certification should also identify any data issues or other caveats that the auditor identified as impacting the results of the audit.

Medicaid State Plan Rate Year means the 12-month period defined by a State's approved Medicaid State plan in which the State estimates eligible uncompensated care costs and determines corresponding disproportionate share hospital payments as well as all other Medicaid payment rates. The period usually corresponds with the State's fiscal year or the Federal fiscal year but can correspond to any 12-month period defined by the State as the Medicaid State plan rate year.

Sec. 455.304 Condition for Federal financial participation (FFP).

(a) General rule.

(1) The State must submit an independent certified audit to CMS for each completed Medicaid State plan rate year, consistent with the requirements in this subpart, to receive Federal payments under Section 1903(a)(1) of the Act based on State expenditures for disproportionate share hospital (DSH) payments for Medicaid State plan rate years subsequent to the date the audit is due, except as provided in paragraph (e) of this section.

(2) FFP is not available in expenditures for DSH payments that are found in the independent certified audit to exceed the hospital-specific eligible uncompensated care cost limit, except as provided in paragraph (e) of this section.

(b) Timing.

For Medicaid State plan rate years 2005 and 2006, a State must submit to CMS an independent certified audit report no later than the last day of calendar ear 2009. Each subsequent audit beginning with Medicaid State plan rate year 2007 must be completed by the last day of the Federal fiscal year ending three years from the end of the Medicaid State plan rate year under audit. Completed audit reports must be submitted to CMS no later than 90 days after completion. Post-audit adjustments based on claims for the Medicaid State plan rate year paid subsequent to the audit date, if any, must be submitted in the quarter the claim was paid.

(c) Documentation.

In order to complete the independent certified audit, States must use the following data sources:

(1) Approved Medicaid State plan for the Medicaid State plan rate year under audit.

(2) Payment and utilization information from the State's Medicaid Management Information System.

(3) The Medicare 2552-96 hospital cost report(s) applicable to the Medicaid State plan rate year under audit. If the Medicare 2552-96 is superseded by an alternate Medicare developed cost reporting tool during an audit year, that tool must be used for the Medicaid State plan rate year under audit.

(4) Audited hospital financial statements and hospital accounting records.

(d) Specific requirements.

The independent certified audit report must verify the following:

(1) Verification 1: Each hospital that qualifies for a DSH payment in the State is allowed to retain that payment so that the payment is available to offset its uncompensated care costs for furnishing inpatient hospital and outpatient hospital services during the Medicaid State plan rate year to Medicaid eligible individuals and individuals with no source of third party coverage for the services in order to reflect the total amount of claimed DSH expenditures.

(2) Verification 2: DSH payments made to each qualifying hospital comply with the hospital-specific DSH payment limit. For each audited Medicaid State plan rate year, the DSH payments made in that audited Medicaid State plan rate year must be measured against the actual uncompensated care cost in that same audited Medicaid State plan rate year.

(3) Verification 3: 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 Act are eligible for inclusion in the calculation of the hospital-specific disproportionate share limit payment limit, as described in Section 1923(g)(1)(A) of the Act.

(4) Verification 4: For purposes of this hospital-specific limit calculation, any Medicaid payments (including regular Medicaid fee-for-service rate payments, supplemental/enhanced Medicaid payments, and Medicaid managed care organization payments) made to a disproportionate share hospital for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individuals, which 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.

(5) Verification 5: Any 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.

(6) Verification 6: The information specified in paragraph (d)(5)
of this Section includes a description of the methodology for calculating each hospital's payment limit under Section 1923(g)(1) of the Act. Included in the description of the methodology, the audit report must specify 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.

(e) Transition Provisions:

To ensure a period for developing and refining reporting and auditing techniques, findings of State reports and audits for Medicaid State Plan years 2005-2010 will not be given weight except to the extent that the findings draw into question the reasonableness of State uncompensated care cost estimates used for calculations of prospective DSH payments for Medicaid State plan year 2011 and thereafter.

(Catalog of Federal Domestic Assistance Program No. 93.778, Medical Assistance Program)

Dated: September 25, 2008.

Kerry Weems,

Acting Administrator, Centers for Medicare & Medicaid Services.

Approved: October 29, 2008.

Michael O. Leavitt,

Secretary.

Attachment C, Draft Audit and Reporting Protocol

Areas of Responsibility
States:

1. States are responsible for obtaining the independent audit on an annual basis

In response to the statutory language, “independent,” audits must be certified by Single State Audit Agency or any other CPA firm that operates independently from the Medicaid agency and the subject hospitals. States may not rely on non-CPA firms, fiscal intermediary, independent certification programs currently in place to audit UCC, nor expand hospital financial statements to obtain audit certification of the hospital specific DSH limits.

The Single State Audit is an Office of Inspector General process. Although there may be some overlap in resources used to complete both audits, the DSH Audit is particular to Medicaid and is the sole responsibility of CMS to enforce and monitor and thus cannot be combined within the Single State Audit Act.

2. Providing the auditor and the DSH hospitals subject to audit with instructions on the data elements necessary to insure compliance

The DSH audit will rely on existing cost reporting tools and documents as primary sources for the data necessary to evaluate DSH payments against hospital specific DSH costs. Two of the primary source documents are the Medicare 2552-96 hospital cost report and audited hospital financial statements (and other auditable hospital accounting records). Rather than requiring that states or hospitals create new documents and potentially new financial standards, CMS will rely on the financial standards that apply to the use of these documents in their current form. Any hospital participating in the Medicare program already completes the Medicare 2552-96 cost report and is familiar with the accounting standards applicable to this document. Similarly, hospital financial statements are subject to certain financial reporting standards to produce the information that will be used in the DSH audit. Each of these documents will produce data used to develop cost and payment information for the DSH audit using the financial reporting standards applicable to each.

Developing audit protocol for use by DSH hospitals to determine costs. This protocol should include instructions identifying the relevant sections of the cost report that reflect costs eligible for inclusion in developing the hospital specific DSH limit and must replace any current DSH survey information utilized by states. This protocol should include identification of all relevant hospital cost reports and financial statements and other auditable hospital accounting records associated with the audited Medicaid State plan rate year. Situations in which a hospitals fiscal year does not coincide with the Medicaid State plan rate year, hospitals will need to provide the two (or more, if there are short-period, i.e., less than twelve-month, cost reports involved) overlapping cost reports and financial statements and other auditable hospital accounting records to properly reflect cost incurred during the full State Plan rate year.

3. Provide DSH hospitals and auditor with fee for service (FFS) Medicaid IP and OP hospital days and charges based on Medicaid Management Information System (MMIS) data for the cost reporting period(s) covering the Medicaid State plan rate year under audit.

4. Provide DSH hospitals and auditor with all information related to IP/OP hospital regular Medicaid rate payments (including all rate add-ons), all Medicaid supplemental and enhanced payments, and all DSH payments made to each DSH hospital for the cost reporting year(s) covering the State plan rate year.

5. Provide auditor with methodologies utilized by the State to determine DSH eligible hospitals under the Medicaid State plan (LIUR, MIUR, Other) and payment methodologies used to generate DSH payments under the approved Medicaid State plan.

6. Provide auditor with hospital-generated IP/OP hospital cost report information; Medicaid managed care IP/OP hospital days, charges, and payment information; and uninsured IP/OP hospital days, charges, and payment information received from DSH hospitals.

7. Report the findings of the audit to CMS within 90 days of receiving audit. In recognition of timing issues related to initiating the audit process. States may concurrently complete the Medicaid State plan rate year 2005 and 2006 audits by September 30, 2009. The report associated with Medicaid State plan rate years 2005 and 2006 are due no later than December 31, 2009 to CMS.

8. Use audit findings for rate year 2005 – 2010 to prospectively adjust DSH payments beginning with Medicaid State plan rate year 2011.

9. Use audit findings for rate year 2011 to determine over/underpayments (final report available in 2014).

DSH Hospitals:

1. Use the Medicare 2552-96 hospital cost report to determine cost center specific routine per diems and ancillary ratios of cost to charges (RCC) based on Medicare Cost Principles (Medicare cost allocation process).

2. Utilize MMIS data provided by the state for Medicaid FFS IP/OP hospital ancillary charges and Medicaid FFS IP hospital routine days.

3. Utilize hospital financial statements and other auditable hospital accounting records as source for IP/OP hospital Medicaid managed care ancillary charges and routine days and IP/OP hospital uninsured ancillary charges and routine days (individuals with no source of third party coverage). These charges and days will be used with cost center specific RCCs and per diems, respectively, to allocate hospital costs to each relevant payer category described above.

4. Utilize revenue information from financial statements and other auditable hospital accounting records to identify payments made by or on behalf of patients with no source of third party coverage for IP/OP hospital services. Note that payments for IP/OP hospital services from state-only or local-only programs for the uninsured should not be included as revenues.

5. Utilize revenue information from financial statements and other auditable hospital accounting records to identify Medicaid payments not directly paid by the State in which the hospital is located, including all IP/OP Title XIX payments from other States (regular, supplemental and enhanced and DSH), all payments from Medicaid managed care organizations for IP/OP hospital services provided to Medicaid MCO enrollees, and all payments from other non-State sources for Medicaid IP/OP hospital services.

6. Provide state with hospital specific cost and revenue data, including backup documentation, so that independent auditor may utilize in developing audit report. Continue to provide state information already required to determine DSH qualifications (LIUR, MIUR, other).

Auditor:

1. Review State's methodology for estimating hospital's OBRA 1993 hospital-specific DSH limit and the State's DSH payment methodologies in the approved Medicaid State plan for the State plan rate year under audit.

2. Review state's DSH audit protocol to ensure consistency with IP/OP Medicaid reimbursable services in the approved Medicaid State plan. Review DSH audit protocol to ensure that only costs eligible for DSH payments are included in the development of the hospital specific DSH limit.

3. Compile hospital specific IP/OP cost report data and IP/OP revenue data to measure hospital specific DSH limit in auditable year. In determining this limit, the auditor must measure both components of the hospital specific DSH limit. To determine the existence of a Medicaid shortfall, Medicaid IP/OP hospital costs (including Medicaid managed care costs) must be measured against Medicaid IP/OP revenue received for such services in the audited State Plan rate year (including regular Medicaid rate payments, add-ons, supplemental and enhanced payments and Medicaid managed care revenues). Costs associated with patients with no source of third party coverage must be reduced by applicable revenues and added to any Medicaid shortfall to determine total eligible DSH costs.

4. Compile total DSH payments made in auditable year to each qualifying hospital (including DSH payments received by the hospitals from other States).

5. Compare hospital specific DSH costs limits against hospital specific total DSH payments in the audited Medicaid State plan rate year. Summarize findings identifying any overpayments/underpayments to particular hospitals.

Data Sources:

The following are to be considered the primary data sources utilized by states, hospitals and the independent auditors to complete the DSH audit and the accompanying report. In many instances, hospital financial and cost report periods will differ from the Medicaid State plan rate year. In these instances, hospitals should use multiple audited financial reports and hospital cost reports to fully cover the Medicaid State plan rate year under audit. The data should be directly allocated based on the months covered by the financial or cost reporting period that directly related to the Medicaid State plan period under audit. For instance, if a Medicaid State plan rate year runs from 7/1/04 to 6/30/05 but a DSH hospital receiving payments under the Medicaid State plan operates its financial and cost reporting based on a calendar year, the hospital would need to use financial and cost reports for calendar years 2004 and 2005. The hospital would allocate 50% of all costs and revenues in each financial and cost reporting period to determine costs and revenues associated with the Medicaid State plan rate year 2005.

1. MMIS Data

State MMIS generated IP hospital payments, ancillary charges and routine days for the cost reporting period(s) covering the Medicaid State plan rate year under audit for each DSH hospital.

State MMIS generated OP hospital payments and ancillary charges for the cost reporting period(s) covering the Medicaid State plan rate year under audit for each DSH hospital.

2. Approved Medicaid State Plan

LIUR, MIUR or other DSH hospital determination criteria and data used to determine eligibility for the Medicaid State plan rate year under audit.

Medicaid State Plan DSH payment methodologies for the Medicaid State plan rate year under audit.

State DSH payments to each DSH hospital for the Medicaid State plan rate year under audit.

State methodology for determining the hospital-specific DSH limit, the data used to determine such limit and the hospital-specific cost limit generated by methodology and data for the Medicaid State plan rate year under audit.

3. Medicare 2552-96 Hospital Cost Report

Medicare 2552-96 hospital cost report(s) for the Medicaid State plan rate year under audit (finalized when available, or as filed).

4. Audited Hospital Financial Statements and Other Auditable Hospital Accounting Records

Hospital revenues from Medicaid managed care organizations, Medicaid payments from other States (regular payments including add-ons, supplemental and enhanced payments, DSH payments), and Medicaid IP/OP hospital payments from all sources other than the State from hospital financial reports and records for the cost reporting period(s) covering the Medicaid State plan rate year under audit.

Hospital revenues from or on behalf of with no source of third party coverage for the hospital services provided.

Days and charges for IP/OP Medicaid hospital services for services provided to out of state Medicaid patients.

Days and charges for IP/OP hospital services provided to patients with no source of third party coverage for the hospital services provided.

Days and charges for IP/OP hospital services provided to Medicaid managed care patients.

General Cost Determination: Uncompensated Care Cost Determination

Hospitals must use the Medicare 2552-96 Hospital Cost Report(s) for the Medicaid State plan rate year to determine allowable IP/OP Medicaid service costs and costs of providing IP/OP hospital services to patients with no source of third party coverage for the hospital services provided.

The Medicare cost allocation process will be used to determine facility costs for inclusion in determining DSH eligible hospital costs. In order to provide complete financial information for the Medicaid State plan rate year under audit, hospitals must use two or more Medicare costs reports if the cost reporting period does not correspond with the Medicaid State plan rate year under audit. Once costs are allocated according to the Medicare cost allocation process, those costs should be allocated to the Medicaid State plan rate year on a pro-rata basis to develop 12 full months of costs.

1. Hospitals determine IP FFS Medicaid costs

Hospitals must follow the cost reporting and apportionment process as prescribed by the 2552-96. In the 2552-96, a per diem is computed for each routine cost center, and a cost-to-charge ratio is computed for each ancillary/non-routine cost center. In the Worksheet D series of the 2552-96, total allowable costs from each routine cost center are apportioned to a specific program by applying that cost center's program days to the cost center's computed per diem, and total allowable costs from each ancillary/non-routine cost center are apportioned to a specific program by applying that cost center's program charges to the cost center's computed cost-to-charge ratio.

The program data used in this apportionment process in determining hospital inpatient fee-for-service Medicaid costs are the days and charges pertaining to hospital inpatient services furnished to Medicaid fee-for-service individuals. The primary source of the program data is the MMIS. The program days and charges must pertain: a) only to services furnished by the hospital and its departments and not by any non-hospital component (even if such component is deemed to be hospital-based); b) only to inpatient hospital services and not services furnished by practitioners which can be billed separately as professional services; and c) only to services paid by Title XIX fee-for-service. As required by the 2552-96 cost report apportionment process, the program data must be reported by hospital cost centers.
By applying program days defined above to the cost-report-computed per diems and applying program charges defined above to the cost report-computed cost-to-charge ratios, and by following the established 2552-96 cost reporting and apportionment process, the hospital will determine its hospital inpatient fee-for-service Medicaid cost

2. Hospitals determine IP Medicaid managed care costs

Hospitals must follow the cost reporting and apportionment process as prescribed by the 2552-96. In the 2552-96, a per diem is computed for each routine cost center, and a cost-to-charge ratio is computed for each ancillary/non-routine cost center. In the Worksheet D series of the 2552-96, total allowable costs from each routine cost center are apportioned to a specific program by applying that cost center's program days to the cost center's computed per diem, and total allowable costs from each ancillary/non-routine cost center are apportioned to a specific program by applying that cost center's program charges to the cost center's computed cost-to-charge ratio.

The program data used in this apportionment process in determining hospital inpatient Medicaid managed care costs are the days and charges pertaining to hospital inpatient services furnished to individuals under Medicaid managed care. The program data must be derived from auditable documentation and may include reports from Medicaid managed care plans. The auditable documentation must show that the program days and charges pertain: a) only to services furnished by the hospital and its departments and not by any non-hospital component (even if such component is deemed to be hospital-based); b) only to inpatient hospital services and not services furnished by practitioners which can be billed separately as professional services; and c) only to Title XIX services paid by the Medicaid managed care plans. As required by the 2552-96 cost report apportionment process, the program data must be reported by hospital cost centers.

By applying program days defined above to the cost-report-computed per diems and applying program charges defined above to the cost-report-computed cost-to-charge ratios, and by following the established 2552-96 cost reporting and apportionment process, the hospital will determine its hospital inpatient Medicaid managed care cost.

3. Hospitals determine IP costs for hospital services provided to patients with no source of third party coverage

Hospitals must follow the cost reporting and apportionment process as prescribed by the 2552-96. In the 2552-96, a per diem is computed for each routine cost center, and a cost-to-charge ratio is computed for each ancillary/non-routine cost center. In the Worksheet D series of the 2552-96, total allowable costs from each routine cost center are apportioned to a specific program by applying that cost center's program days to the cost center's computed per diem, and total allowable costs from each ancillary/non-routine cost center are apportioned to a specific program by applying that cost center's program charges to the cost center's computed cost-to-charge ratio.

The program data used in this apportionment process in determining hospital uninsured inpatient costs are the days and charges pertaining to hospital inpatient services furnished to individuals who have no source of third party coverage. The program data must be derived from auditable documentation. The auditable documentation must show that the program days and charges pertain: a) only to services furnished by the hospital and its departments and not by any non-hospital component (even if such component is deemed to be hospital-based); b) only to inpatient hospital services and not services furnished by practitioners which can be billed separately as professional services; and c) only to services furnished to individuals who have no source of third party coverage (services furnished to individuals who are covered only by state-only/local governmental programs may be included). As required by the 2552-96 cost report apportionment process, the program data must be reported by hospital cost centers.

By applying the program days defined above to the cost-report-computed per diems and applying the program charges defined above to the cost-report-computed cost-to-charge ratios, and by following the established 2552-96 cost reporting and apportionment process, the hospital will determine its hospital uninsured inpatient cost.

4. Hospitals determine OP FFS Medicaid costs

Hospitals must follow the cost reporting and apportionment process as prescribed by the 2552-96. In the 2552-96, a cost-to-charge ratio is computed for each ancillary/non-routine cost center. In the Worksheet D series of the 2552-96, total allowable costs from each ancillary/non-routine cost center are apportioned to a specific program by applying that cost center's program charges to the cost center's computed cost-to-charge ratio.

The program data used in this apportionment process in determining hospital outpatient fee-for-service Medicaid costs are the charges pertaining to hospital outpatient services furnished to Medicaid fee-for-service individuals. The primary source of the program data is the MMIS. The program charges must pertain: a) only to services furnished by the hospital and its departments and not by any non-hospital component (even if such component is deemed to be hospital-based); b) only to outpatient hospital services furnished and not services furnished by practitioners which can be billed separately as professional services; and c) only to services paid by Title XIX fee-for-service. As required by the 2552-96 cost report apportionment process, the program data must be reported by hospital cost centers.
By applying the program charges defined above to the cost-report-computed cost-to-charge ratios and by following the established 2552-96 cost reporting and apportionment process, the hospital will determine its hospital outpatient fee-for-service Medicaid cost.

5. Hospitals determine OP Medicaid managed care costs

Hospitals must follow the cost reporting and apportionment process as prescribed by the 2552-96. In the 2552-96, a cost-to-charge ratio is computed for each ancillary/non-routine cost center. In the Worksheet D series of the 2552-96, total allowable costs from each ancillary/non-routine cost center are apportioned to a specific program by applying that cost center's program charges to the cost center's computed cost-to-charge ratio.

The program data used in this apportionment process in determining hospital outpatient Medicaid managed care costs are the charges pertaining to hospital outpatient services furnished to individuals under Medicaid managed care. The program data must be derived from auditable documentation and may include reports from Medicaid managed care plans. The auditable documentation must show that the program charges pertain: a) only to services furnished by the hospital and its departments and not by any non-hospital component (even if such component is deemed to be hospital-based); b) only to OP hospital services and not services furnished by practitioners which can be billed separately as professional services; and c) only to Title XIX services paid by the Medicaid managed care plans. As required by the 2552-96 cost report apportionment process, the program data must be reported by hospital cost centers.

By applying program charges defined above to the cost-report-computed cost-to-charge ratios and by following the established 2552-96 cost reporting and apportionment process, the hospital will determine its hospital outpatient Medicaid managed care cost.

6. Hospitals determine OP costs for hospital services provided to patients with no source of third party coverage

Hospitals must follow the cost reporting and apportionment process as prescribed by the 2552-96. In the 2552-96, a cost-to-charge ratio is computed for each ancillary/non-routine cost center. In the Worksheet D series of the 2552-96, total allowable costs from each ancillary/non-routine cost center are apportioned to a specific program by applying that cost center's program charges to the cost center's computed cost-to-charge ratio.

The program data used in this apportionment process in determining hospital uninsured outpatient costs are the charges pertaining to hospital outpatient services furnished to individuals who have no source of third party coverage. The program data must be derived from auditable documentation. The auditable documentation must show that the program charges pertain: a) only to services furnished by the hospital and its departments and not by any non-hospital component (even if such component is deemed to be hospital-based); b) only to OP hospital services and not services furnished by practitioners which can be billed separately as professional services; and c) only to services furnished to individuals who have no source of third party coverage (services furnished to individuals who are covered only by state-only/local governmental programs may be included). As required by the 2552-96 cost report apportionment process, the program data must be reported by hospital cost centers.
By applying the program charges defined above to the cost-report-computed cost-to-charge ratios and by following the established 2552-96 cost reporting and apportionment process, the hospital will determine its hospital uninsured outpatient cost.

7. Hospital report revenues from Medicaid managed care organizations, Medicaid payments from other States (regular payments including add-ons, supplemental and enhanced payments, DSH payments), and other non-State Medicaid payments

Since the State's MMIS system will not have information about payments generated from Medicaid managed care organizations or Medicaid and DSH payments from other States and other non-State sources, hospitals must use their financial statements and other auditable hospital accounting records to identify:

All Medicaid managed care payments received during the cost reporting period(s) covering the Medicaid State plan rate year under audit. Any managed care payments received that include payments for services other than those that qualify for IP or OP hospital services must be separated to include that portion of the payment applicable to IP or OP hospital services. If the hospital cannot separate the component parts of a managed care payment, the full amount of the payment must be counted as in IP/OP hospital managed care payment.

All Medicaid payments received from out of state during the cost reporting period(s) covering the Medicaid State Plan rate year under audit. Hospitals must separately identify a) Medicaid regular rate payments (including add-ons); b) supplemental Medicaid payments, and; c) DSH payments.
All Medicaid payments received during the cost reporting period(s) covering the Medicaid State plan rate year under audit from non-State sources not already accounted for, including payments from or on behalf of patients for Medicaid services.

8. Hospital report revenue from or on behalf of patients with no source of third party coverage for the hospital services provided

Since the State's MMIS system will not have information about payments by or on behalf of patients with no source of third party coverage for the hospital services provided, hospitals must use their financial statements and other auditable hospital accounting records to identify:

All payments received during cost reporting period(s) covering the Medicaid State plan rate year under audit by or on behalf of patients with no source of third party coverage. There will be no attempt to allocate payments received during the state plan rate year to services provided in prior periods. Since the goal of the audit is to determine uncompensated DSH costs in a given Medicaid State plan rate year, all payments received in the year will be counted as revenue to the hospital in that same year. It is understood that some costs incurred during the State Plan rate year under audit may be associated with future revenue streams (legal decisions, payment plans, recoveries) but that the payments are not counted as revenue until actually received.

IP or OP hospital payments received from state or local government programs for individuals with no source of third party coverage for the hospital services they received should not be included as a revenue in this category.

9. Auditor applies MMIS generated total IP/OP hospital Medicaid FFS payments (other than DSH) to total IP/OP hospital Medicaid FFS cost

10. Auditor applies IP/OP hospital Medicaid managed care revenues against IP/OP hospital Medicaid managed care costs

11. Auditor applies IP/OP hospital revenues for patients with no source of third party coverage against the costs for IP/OP hospital services provided to such individuals

12. Sum of steps 9-11 are summed to determine the total amount of costs eligible for DSH reimbursement and considered the OBRA 1993 hospital specific DSH limit

13. Compare DSH payments to the amount determined in step 12

Attachment D

Facility Name	Medicare Number	Public Status	$ Available for DSH	2005 Regular DSH Payments	2005 Small Hospital DSH Payments	2005 Indigent Care Agreements DSH Payments	2005 Managed Care Pool DSH Payments	2005 Public DSH Payments	2005 State Psych DSH Payments
Allegan General Hospital	23-0042	Private	$ 3,919,407	$ 107,467	$ 10,516	$ 265,456		$ -	
Alpena General Hospital	23-0036	Public	$ 4,131,264	$ 56,945	$ 21,685	$ -		$ 4,052,634	
Baraga County Memorial Hospital	23-1307	Public	$ 457,062	$ -	$ 501	$ -		$ 456,561	
Battle Creek Health System	23-0075	Private	$ 14,285,436	$ 5,828	$ 107,135	$ 288,750		$ -	
Bay Medical Center	23-0041	Private	$ 905,049	$ 37,664	$ 81,852	$ 637,405		$ -	
Bell Memorial Hospital	23-1321	Private	$ 1,282,727	$ 35,543	$ 14,810	$ 490,743		$ -	
Bi-County Community Hospital	23-0204	Private	$ 6,325,491	$ -	$ 15,041	$ -		$ -	
Bon Secours Hospital	23-0089	Private	$ (8,966,138)	$ -	$ -	$ -		$ -	
Borgess Hospital	23-0117	Private	$ 35,036,238	$ 104,383	$ -	$ 1,497,221		$ -	
Botsford General Hospital	23-0151	Private	$ 19,169,737	$ -	$ 66,098	$ -		$ -	
Bronson Methodist Hospital	23-0017	Private	$ 34,661,008	$ 455,087	$ 343,782	$ 1,729,993	$ 2,772,003	$ -	
Bronson Vicksburg Hospital	23-0190	Private	$ 1,065,798	$ -	$ 929	$ -		$ -	
CareLink of Jackson	23-2036	Private	$ 527,192	$ -	$ -	$ -		$ -	
Caro Community Hospital	23-0235	Private	$ 429,656	$ -	$ 153	$ -		$ -	
Carson City Osteopathic Hospital	23-0208	Private	$ 2,467,913	$ 38,702	$ 13,538	$ 1,289,514		$ -	
Central Michigan Community Hospital	23-0080	Private	$ 1,057,433	$ -	$ 13,788	$ -		$ -	
Charlevoix Area Hospital	23-1322	Private	$ 626,360	$ -	$ 3,782	$ 502,754		$ -	
Cheboygan Memorial Hospital	23-0034	Private	$ 321,273	$ -	$ 5,810	$ -		$ -	
Chelsea Community Hospital	23-0259	Private	$ 3,741,285	$ 114,323	$ 3,427	$ 1,448,805		$ -	
Children's Hospital of Michigan	23-3300	Private	$ 47,254,286	$ 17,257,289	$ -	$ -		$ -	
Chippewa War Memorial Hospital	23-0239	Private	$ 1,330,116	$ -	$ 8,446	$ -		$ -	
Clinton Memorial Hospital	23-0103	Private	$ 662,870	$ -	$ 713	$ -		$ -	
Community Health Center of Branch County	23-0022	Public	$ 3,071,801	$ -	$ 9,740	$ -		$ 3,062,061	
Community Hospital - Watervliet	23-0078	Private	$ 3,107,345	$ 13,741	$ 15,499	$ -		$ -	
Cottage Hospital of Grosse Pointe	23-0135	Private	$ 2,437,038	$ 120,131	$ 19,957	$ -		$ -	
Covenant Medical Center, Inc.	23-0070	Private	$ 15,040,046	$ -	$ 313,407	$ 2,887,504		$ -	
Crittenton Hospital	23-0254	Private	$ 8,260,292	$ 18,687	$ 6,089	$ -		$ -	
Deckerville Community Hospital	23-1311	Private	$ 434,500	$ -	$ -	$ -		$ -	
Detroit Receiving Hospital	23-0273	Private	$ 90,457,176	$ 7,842,467	$ -	$ 9,620,004		$ -	
Dickinson County Memorial Hospital	23-0055	Public	$ 2,928,847	$ -	$ 11,246	$ -		$ 2,917,601	
Eaton Rapids Medical Center	23-0153	Private	$ 429,338	$ -	$ -	$ -		$ -	
Edward W. Sparrow Hospital	23-0230	Private	$ 38,227,702	$ 10,778	$ 476,737	$ 10,016,070		$ -	
Emma L. Bixby Medical Center	23-0005	Private	$ 7,304,094	$ 5,946	$ 18,424	$ -		$ -	
Forest Health Medical Center, Inc.	23-0144	Private	$ -	$ -	$ -	$ -		$ -	
Forest View Psychiatric Hospital	23-4030	Private	$ 200,828	$ -	$ -	$ -		$ -	
Garden City Osteopathic Hospital	23-0244	Private	$ 6,823,115	$ -	$ 59,417	$ -		$ -	
Genesys Regional Medical Center	23-0197	Private	$ 12,494,613	$ -	$ -	$ 10,983,228		$ -	
Gerber Memorial Hospital	23-0106	Private	$ 4,775,908	$ 112,979	$ 40,816	$ 1,001,001		$ -	
Grand View Hospital	23-0143	Private	$ 1,521,183	$ -	$ 1,357	$ 67,527		$ -	
Gratiot Community Hospital	23-0030	Private	$ 2,415,270	$ -	$ 9,222	$ -		$ -	
Hackley Hospital	23-0066	Private	$ 9,839,130	$ 79,613	$ 65,532	$ 1,254,707		$ -	
Harbor Beach Community Hospital	23-1313	Private	$ 160,129	$ -	$ -	$ -		$ -	
Harbor Oaks Hospital	23-4021	Private	$ 3,044,633	$ -	$ -	$ -		$ -	
Harper University Hospital	23-0104	Private	$ 109,344,430	$ 4,750,413	$ -	$ 54,547,142		$ -	
Havenwyck Hospital	23-4023	Private	$ (100,519)	$ -	$ -	$ -		$ -	
Hayes Green Beach Memorial Hospital	23-0006	Private	$ 1,974,813	$ 23,932	$ 6,361	$ 375,375		$ -	
Healthsource Saginaw	23-0275	Public	$ 340,681	$ 71,311	$ 18,843	$ -		$ 250,527	
Helen Newberry Joy Hospital	23-1304	Public	$ 919,465	$ -	$ 708	$ -		$ 918,757	
Henry Ford Hospital	23-0053	Private	$ 65,510,187	$ 36,236	$ 427,287	$ 607,387		$ -	
Henry Ford Wyandotte Hospital	23-0146	Private	$ 6,080,492	$ 493,582	$ 106,236	$ -		$ -	
Herrick Memorial Hospital, Inc.	23-0120	Private	$ 4,742,300	$ 10,104	$ 4,366	$ -		$ -	

Hills & Dales General Hospital	23-1316	Private	$ 634,776	$ -	$ 376	$ -	$	-
Hillsdale Community Health Center	23-0037	Private	$ 2,638,527	$ -	$ 6,227	$ 300,000	$	-
Holland Community Hospital	23-0072	Private	$ 6,140,099	$ -	$ 31,550	$ -	$	-
Hurley Medical Center	23-0132	Public	$ 18,089,609	$ 2,799,135	$ -	$ -	$	15,290,474
Huron Memorial Hospital	23-0118	Private	$ 906,660	$ -	$ 5,610	$ -	$	-
Huron Valley - Sinai Hospital	23-0277	Private	$ 2,483,424	$ -	$ -	$ -	$	-
Ingham Regional Medical Center	23-0167	Private	$ 11,396,400	$ -	$ 52,365	$ 5,682,332	$	-
Ionia County Memorial Hospital	23-0027	Private	$ 709,116	$ 856	$ 4,966	$ 393,921	$	-
Iron County General Hospital	23-1318	Private	$ 981,739	$ -	$ -	$ -	$	-
Kalkaska Memorial Health Center	23-1301	Public	$ 634,303	$ -	$ 38	$ -	$	634,265
Kelsey Memorial Hospital	23-1317	Private	$ 539,202	$ -	$ -	$ -	$	-
Keweenaw Memorial Medical Center	23-1319	Private	$ 523,606	$ -	$ 2,520	$ -	$	-
Kindred Hospital - Detroit	23-2019	Private	$ 1,191,462	$ -	$ -	$ -	$	-
Kingswood Psychiatric Hospital	23-4011	Private	$ 1,563,178	$ 595,786	$ 148,456	$ -	$	-
Lake View Community Hospital	23-0172	Private	$ 1,739,222	$ -	$ 965	$ -	$	-
Lakeland Hospital - St. Joseph	23-0021	Private	$ 13,864,981	$ 31,843	$ 104,865	$ 1,342,317	$	-
Lakeland Speciality Hospital at Berrien Center	23-2025	Private	$ 74,967	$ -	$ -	$ -	$	-
Lakeshore Community Hospital	23-1320	Private	$ 1,008,444	$ 6,550	$ 4,233	$ -	$	-
Lapeer Regional Hospital	23-0193	Private	$ 1,006,633	$ 33,578	$ 27,569	$ -	$	-
Lee Memorial Hospital	23-1315	Private	$ 2,262,722	$ -	$ -	$ -	$	-
Leelanau Memorial Hospital	23-1302	Private	$ 101,823	$ -	$ -	$ -	$	-
LifeCare Hospitals of Western Michigan	23-2026	Private	$ -	$ -	$ -	$ -	$	-
Mackinac Straits Hospital	23-1306	Public	$ 464,731	$ -	$ 9	$ -	$	464,722
Marlette Community Hospital	23-0082	Private	$ 238,356	$ -	$ 755	$ -	$	-
Marquette General Hospital	23-0054	Private	$ 4,957,039	$ 120,764	$ 71,795	$ 2,583,798	$	-
Mary Free Bed Hospital & Rehabilitation Center	23-3026	Private	$ 817,395	$ -	$ 1,921	$ -	$	-
McKenzie Memorial Hospital	23-1314	Private	$ 469,898	$ -	$ 3,194	$ -	$	-
McLaren Regional Medical Center	23-0141	Private	$ 13,514,905	$ 322,330	$ 47,415	$ 11,800,786	$	-
Mecosta County General Hospital	23-0093	Public	$ 1,132,713	$ -	$ 12,885	$ -	$	1,119,828
Memorial Healthcare	23-0121	Private	$ 1,464,114	$ -	$ 21,434	$ -	$	-
Memorial Medical Center of West Michigan	23-0110	Private	$ 3,505,111	$ 88,465	$ 25,835	$ 1,001,001	$	-
Mercy General Health Partners	23-0004	Private	$ 10,344,304	$ -	$ 63,671	$ 2,220,570	$	-
Mercy Hospital - Cadillac	23-0081	Private	$ 1,298,488	$ -	$ 14,828	$ -	$	-
Mercy Hospital - Grayling	23-0058	Private	$ 1,858,651	$ -	$ 14,329	$ 1,001,001	$	-
Mercy Hospital - Port Huron	23-0031	Private	$ 3,107,195	$ -	$ 12,820	$ -	$	-
Mercy Memorial Hospital	23-0099	Private	$ 3,536,351	$ -	$ 12,833	$ -	$	-
Metropolitan Hospital - Grand Rapids	23-0236	Private	$ 19,682,685	$ -	$ 28,288	$ 1,155,000	$	-
Mid Michigan Medical Center-Gladwin	23-0189	Private	$ 672,562	$ -	$ 3,820	$ 430,527	$	-
Mid Michigan Reg. Med. Ctr - Midland	23-0222	Private	$ 4,086,482	$ 100,196	$ 37,026	$ 1,850,157	$	-
Mid-Michigan Medical Center-Clare	23-0180	Private	$ 1,666,357	$ 48,656	$ 31,550	$ 1,250,001	$	-
Mt. Clemens General Hospital	23-0227	Private	$ 15,941,089	$ -	$ 116,553	$ 5,197,505	$	-
Munising Memorial Hospital	23-1308	Private	$ 311,795	$ -	$ -	$ -	$	-
Munson Medical Center	23-0097	Private	$ 2,129,726	$ 27,140	$ 76,951	$ 1,326,971	$	-
North Oakland Medical Center	23-0013	Private	$ 8,339,805	$ 219,491	$ 156,024	$ -	$	-
North Ottawa Community Hospital	23-0174	Private	$ 975,922	$ -	$ 2,875	$ -	$	-
Northern Michigan Hospitals, Inc.	23-0105	Private	$ 2,345,112	$ 14,452	$ 26,731	$ 1,371,217	$	-
Oakland Regional Hospital	23-3028	Private	$ 825,425	$ -	$ -	$ -	$	-
Oaklawn Hospital	23-0217	Private	$ 2,565,878	$ -	$ 13,174	$ -	$	-
Oakwood Annapolis Hospital	23-0142	Private	$ 4,889,119	$ -	$ -	$ -	$	-
Oakwood Heritage Hospital	23-0270	Private	$ 8,591,285	$ 1,005,235	$ -	$ -	$	-
Oakwood Hospital and Medical Center	23-0020	Private	$ 33,962,684	$ 228,494	$ -	$ 1,310,296	$	-

Oakwood Southshore Medical Center	23-0176	Private	$ 659,597	$ -	$ -	$ -			$ -			
Ontonagon Memorial Hospital	23-1309	Public	$ 763,198	$ 357	$ 553	$ -			$ 762,288			
Otsego County Memorial Hospital	23-0133	Private	$ 1,978,253	$ -	$ 4,495	$ 724,782			$ -			
Paul Oliver Memorial Hospital	23-1300	Private	$ 401,975	$ -	$ -	$ 208,816			$ -			
Pennock Hospital	23-0040	Private	$ 2,642,027	$ -	$ 11,891	$ 1,126,125			$ -			
Pine Rest Christian Hospital	23-4006	Private	$ 2,509,580	$ -	$ -	$ -			$ -			
POH Medical Center	23-0207	Private	$ 13,752,349	$ 127,629	$ 71,830	$ -			$ -			
Port Huron Hospital	23-0216	Private	$ 5,458,771	$ 52,673	$ 41,865	$ -			$ -			
Portage Health Systems	23-0108	Private	$ 1,191,299	$ -	$ 6,169	$ 443,451			$ -			
Providence Hospital	23-0019	Private	$ 19,772,777	$ 71,355	$ -	$ 983,427			$ -			
Rehabilitation Institute	23-3027	Private	$ 5,433,274	$ 206,895	$ -	$ -			$ -			
Rogers City Rehabilitation Hospital	23-3029	Private	$ (18,978)	$ -	$ -	$ -			$ -			
Saint Mary's Standish Community Hospital	23-1305	Private	$ 245,815	$ -	$ -	$ -			$ -			
SCCI Hospital - Detroit	23-2027	Private	$ (30,066)	$ -	$ -	$ -			$ -			
Scheurer Hospital	23-1310	Private	$ 611,505	$ -	$ 539	$ -			$ -			
Schoolcraft Memorial Hospital	23-1303	Public	$ 856,307	$ -	$ 1,096	$ -			$ 855,211			
Sheridan Community Hospital	23-1312	Private	$ 546,803	$ -	$ 1,631	$ -			$ -			
Sinai-Grace Hospital	23-0024	Private	$ 57,040,147	$ 3,677,875	$ -	$ -			$ -			
South Haven Community Hospital	23-0085	Public	$ 3,474,034	$ 27,151	$ 11,798	$ -			$ 3,435,085			
Southeast Michigan Surgical Hospital	23-0264	Private	$ 514,348	$ -	$ 703	$ -			$ -			
Southwest Regional Rehabilitation Hospital	23-3025	Private	$ 35,832	$ -	$ -	$ -			$ -			
Spectrum Health	23-0038	Private	$ 32,042,031	$ -	$ 405,846	$ 1,841,280			$ -			
Spectrum Health - Kent Community Campus	23-2029	Private	$ 1,695	$ -	$ -	$ -			$ -			
Spectrum Health - Reed City Campus	23-1323	Private	$ 746,575	$ -	$ 2,054	$ -			$ -			
St. Francis Hospital	23-0101	Private	$ 2,498,162	$ -	$ 11,682	$ -			$ -			
St. John - North Shores Hospital	23-0257	Private	$ 371,165	$ -	$ -	$ -			$ -			
St. John Detroit Riverview Hospital	23-0119	Private	$ 19,507,674	$ 2,394,007	$ -	$ -			$ -			
St. John Hospital and Medical Center	23-0165	Private	$ 27,221,817	$ -	$ -	$ 14,423,711			$ -			
St. John Macomb Hospital	23-0195	Private	$ 7,601,015	$ 1,394	$ -	$ -			$ -			
St. John Oakland Hospital	23-0223	Private	$ 9,287,681	$ 127,125	$ -	$ -			$ -			
St. John River District Hospital	23-0241	Private	$ 1,391,873	$ -	$ -	$ -			$ -			
St. Joseph Mercy Hospital - Ann Arbor	23-0156	Private	$ 8,547,799	$ -	$ 50,111	$ 6,469,490			$ -			
St. Joseph Mercy Hospital & Health Services	23-0047	Private	$ 9,165,975	$ -	$ 6,910	$ -			$ -			
St. Joseph Mercy Livingston Hospital	23-0069	Private	$ 548,488	$ -	$ 10,072	$ 412,913			$ -			
St. Joseph Mercy Oakland	23-0029	Private	$ 9,541,533	$ -	$ 38,457	$ -			$ -			
St. Joseph Mercy Saline Hospital	23-0212	Private	$ 257,782	$ -	$ -	$ -			$ -			
St. Mary Mercy Hospital	23-0002	Private	$ 1,559,224	$ -	$ 3,409	$ -			$ -			
St. Mary's Health Care (Grand Rapids)	23-0059	Private	$ 30,097,804	$ 198,365	$ 114,227	$ 1,453,050			$ -			
St. Mary's Medical Center - Saginaw	23-0077	Private	$ 13,999,390	$ -	$ -	$ -			$ -			
Straith Memorial Hospital	23-0071	Private	$ 9,835	$ -	$ -	$ -			$ -			
Sturgis Memorial Hospital	23-0096	Public	$ 1,804,925	$ -	$ 11,155	$ -			$ 1,793,770			
Tawas St. Joseph Hospital	23-0100	Private	$ 1,567,677	$ -	$ -	$ 577,500			$ -			
Three Rivers Area Hospital	23-0015	Public	$ 3,273,738	$ 1,311	$ 9,088	$ -			$ 3,263,339			
United Community Hospital	23-0293	Private	$ 270,099	$ -	$ -	$ -			$ -			
United Memorial Health Center	23-0035	Private	$ 1,866,402	$ -	$ 8,474	$ -			$ -			
University of Michigan Health System	23-0046	Public	$ 42,716,857	$ -	$ 505,793	$ 79,670			$ 42,131,394			
W.A. Foote Memorial Hospital	23-0092	Private	$ 23,155,446	$ 667,741	$ 68,472	$ 1,134,788			$ -			
West Branch Regional Medical Center	23-0095	Public	$ 1,261,646	$ -	$ 9,494	$ -			$ 1,252,152			
West Shore Medical Center	23-0060	Public	$ 1,597,434	$ -	$ 7,714	$ -			$ 1,589,720			
William Beaumont Hospital - Royal Oak	23-0130	Private	$ 54,464,389	$ -	$ 65,149	$ 430,495			$ -			
William Beaumont Hospital - Troy	23-0269	Private	$ 3,132,595	$ -	$ 8,340	$ -			$ -			
Zeeland Community Hospital	23-0003	Private	$ 321,185	$ -	$ 1,277	$ -			$ -			
Subtotal - Hospital DSH Payments			$1,222,331,128	$ 45,000,000	$ 5,000,000	$ 170,037,484		$ 2,772,003	$ 84,250,389			

State Psychiatric Hospitals	
Caro	$ 28,503,564
Kalamazoo	$ 21,104,005
Reuther	$ 31,018,960
Hawthorn	$ 7,101,633
Forensic Facility	$ 45,361,414
Subtotal - Sate Psychiatric Hospitals	$ 133,089,577

Summary of DSH Payments

Total IMD Payments:	**Actual**	**$ 133,089,577**
Total DSH Payments:		**$ 440,149,453**
	Over/(Under) Federal DSH Limit	
	Over/(Under) Federal IMD Limit	

Facility Name	Medicare Number	Public Status	$ Available for DSH	2006 Regular DSH Payments	2006 Small Hospital DSH Payments	2006 Indigent Care Agreements DSH Payments	2006 Managed Care Pool DSH Payments	2006 Government Provider DSH Payments	2006 State Psych DSH Payments
Allegan General Hospital	23-0042	Private	$ 4,736,525	$ 108,647	$ 11,692	$ 265,452		$ -	
Alpena General Hospital	23-0036	Public	$ 6,317,785	$ 65,899	$ 21,278	$ -		$ 6,230,608	
Baraga County Memorial Hospital	23-1307	Public	$ 722,907	$ -	$ 572	$ -		$ 722,335	
Battle Creek Health System	23-0075	Private	$ 13,649,748	$ 172,363	$ 114,317	$ 1,874,104		$ -	
Bay Medical Center	23-0041	Private	$ 1,527,739	$ 13,268	$ 66,233	$ 516,786		$ -	
Bell Memorial Hospital	23-1321	Private	$ 1,139,017	$ 57,113	$ 21,506	$ 575,293		$ -	
Bi-County Community Hospital	23-0204	Private	$ 6,224,163	$ -	$ 12,270	$ -		$ -	
Bon Secours Hospital	23-0089	Private	$ 15,999,151	$ -	$ 50,315	$ -		$ -	
Borgess Hospital	23-0117	Private	$ 35,307,985	$ 57,882	$ -	$ 1,789,717		$ -	
Borgess-Pipp Health Center	23-2034	Private	$ 2,012,690	$ -	$ 42	$ -		$ -	
Botsford General Hospital	23-0151	Private	$ 20,013,806	$ -	$ 54,372	$ -		$ -	
Bronson Methodist Hospital	23-0017	Private	$ 42,704,122	$ 652,591	$ 432,894	$ 5,124,342	$ 2,764,340	$ -	
Bronson Vicksburg Hospital	23-0190	Private	$ 1,054,593	$ -	$ 518	$ -		$ -	
Caro Community Hospital	23-0235	Private	$ 493,424	$ -	$ 347	$ -		$ -	
Carson City Osteopathic Hospital	23-0208	Private	$ 3,213,695	$ 78,092	$ 15,854	$ 1,630,785		$ -	
Central Michigan Community Hospital	23-0080	Private	$ 591,012	$ -	$ 16,056	$ 570,842		$ -	
Charlevoix Area Hospital	23-1322	Private	$ 789,048	$ -	$ 5,068	$ 647,892		$ -	
Cheboygan Memorial Hospital	23-0034	Private	$ 739,624	$ -	$ 7,525	$ -		$ -	
Chelsea Community Hospital	23-0259	Private	$ 3,978,474	$ 159,274	$ 4,364	$ -		$ -	
Children's Hospital of Michigan	23-3300	Private	$ 22,788,633	$ 16,597,032	$ -	$ -		$ -	
Chippewa War Memorial Hospital	23-0239	Private	$ 1,571,395	$ -	$ 11,049	$ 97,300		$ -	
Clinton Memorial Hospital	23-1326	Private	$ 750,125	$ -	$ 396	$ -		$ -	
Community Health Center of Branch County	23-0022	Public	$ 3,698,279	$ -	$ 7,293	$ -		$ 3,690,986	
Community Hospital - Watervliet	23-0078	Private	$ 3,822,414	$ 19,999	$ 10,337	$ -		$ -	
Cottage Hospital of Grosse Pointe	23-0135	Private	$ 6,303,399	$ 386,312	$ 41,668	$ -		$ -	
Covenant Medical Center, Inc.	23-0070	Private	$ 17,477,128	$ -	$ 278,337	$ 3,167,472		$ -	
Crittenton Hospital	23-0254	Private	$ 7,628,717	$ 1,117	$ 3,791	$ -		$ -	
Deckerville Community Hospital	23-1311	Private	$ 433,069	$ -	$ -	$ -		$ -	
Detroit Receiving Hospital	23-0273	Private	$ 61,977,637	$ 7,566,042	$ -	$ 5,000,000		$ -	
Dickinson County Memorial Hospital	23-0055	Public	$ 2,214,616	$ -	$ 6,722	$ -		$ 2,207,894	
Eaton Rapids Medical Center	23-1324	Private	$ 553,047	$ -	$ -	$ -		$ -	
Edward W. Sparrow Hospital	23-0230	Private	$ 42,734,882	$ 2,871	$ 415,113	$ 5,330,476		$ -	
Emma L. Bixby Medical Center	23-0005	Private	$ 5,430,158	$ -	$ 16,449	$ -		$ -	
Forest Health Medical Center, Inc.	23-0144	Private	$ -	$ -	$ -	$ -		$ -	
Forest View Psychiatric Hospital	23-4030	Private	$ (8,461)	$ -	$ -	$ -		$ -	
Garden City Osteopathic Hospital	23-0244	Private	$ 12,939,624	$ 52,784	$ 54,611	$ -		$ -	
Genesys Regional Medical Center	23-0197	Private	$ 17,025,945	$ -	$ -	$ 9,879,480		$ -	
Gerber Memorial Hospital	23-0106	Private	$ 2,751,679	$ 128,567	$ 34,823	$ 1,196,554		$ -	
Grand View Hospital	23-0143	Private	$ 1,755,125	$ -	$ 2,088	$ 293,524		$ -	
Gratiot Community Hospital	23-0030	Private	$ 1,429,799	$ -	$ 6,094	$ -		$ -	
Hackley Hospital	23-0066	Private	$ 10,240,877	$ 59,131	$ 57,737	$ 1,649,052		$ -	
Harbor Beach Community Hospital	23-1313	Private	$ 157,353	$ -	$ -	$ -		$ -	
Harbor Oaks Hospital	23-4021	Private	$ 3,741,428	$ -	$ -	$ -		$ -	
Harper University Hospital	23-0104	Private	$ 103,593,038	$ 4,912,521	$ -	$ 52,317,414		$ -	
Havenwyck Hospital	23-4023	Private	$ (198,657)	$ -	$ -	$ -		$ -	
Hayes Green Beach Memorial Hospital	23-1327	Private	$ 2,043,480	$ 5,847	$ 7,001	$ 1,084,586		$ -	
Healthsource Saginaw	23-0275	Public	$ 420,675	$ 113,903	$ 23,436	$ -		$ 283,336	
Helen Newberry Joy Hospital	23-1304	Public	$ 1,882,861	$ -	$ 910	$ -		$ 1,881,951	
Henry Ford Hospital	23-0053	Private	$ 67,808,983	$ -	$ 376,483	$ 7,518,237		$ -	
Henry Ford Wyandotte Hospital	23-0146	Private	$ 9,729,800	$ 247,647	$ 73,752	$ -		$ -	
Herrick Memorial Hospital, Inc.	23-0120	Private	$ 3,310,841	$ 19,544	$ 4,785	$ -		$ -	
Hills & Dales General Hospital	23-1316	Private	$ 1,057,561	$ -	$ 1,276	$ -		$ -	

Hillsdale Community Health Center	23-0037	Private	$ 4,302,755	$ -	$ 11,328	$ 1,266,225	$	-
Holland Community Hospital	23-0072	Private	$ 9,077,710	$ 84,121	$ 36,174	$ -	$	-
Hurley Medical Center	23-0132	Public	$ 22,102,559	$ 3,472,979	$ -	$ 3,200,000	$	11,429,580
Huron Memorial Hospital	23-0118	Private	$ 616,422	$ -	$ 5,836	$ -	$	-
Huron Valley - Sinai Hospital	23-0277	Private	$ 3,760,685	$ -	$ -	$ -	$	-
Ingham Regional Medical Center	23-0167	Private	$ 14,845,756	$ -	$ 76,372	$ 5,551,053	$	-
Ionia County Memorial Hospital	23-0027	Private	$ 932,753	$ 10,365	$ 6,992	$ 512,587	$	-
Iron County General Hospital	23-1318	Private	$ 497,306	$ -	$ -	$ -	$	-
Kalkaska Memorial Health Center	23-1301	Public	$ 1,736,463	$ 773	$ 211	$ -	$	1,735,479
Kelsey Memorial Health Center	23-1317	Private	$ 442,125	$ -	$ -	$ -	$	-
Keweenaw Memorial Medical Center	23-1319	Private	$ 738,240	$ -	$ 2,237	$ -	$	-
Kindred Hospital - Detroit	23-2019	Private	$ 445,473	$ -	$ -	$ -	$	-
Kingswood Psychiatric Hospital	23-4011	Private	$ (128,788)	$ -	$ -	$ -	$	-
Lake View Community Hospital	23-0172	Private	$ 2,152,854	$ -	$ 578	$ -	$	-
Lakeland Hospital - St. Joseph	23-0021	Private	$ 15,562,771	$ 47,962	$ 99,747	$ 1,607,923	$	-
Lakeland Speciality Hospital at Berrien Center	23-2025	Private	$ 97,177	$ -	$ -	$ -	$	-
Lakeshore Community Hospital	23-1320	Private	$ 803,444	$ 4,701	$ 2,727	$ -	$	-
Lapeer Regional Hospital	23-0193	Private	$ 3,708,732	$ 43,904	$ 23,754	$ -	$	-
Lee Memorial Hospital	23-1315	Private	$ 458,529	$ -	$ -	$ -	$	-
Leelanau Memorial Hospital	23-1302	Private	$ 50,647	$ -	$ -	$ -	$	-
LifeCare Hospitals of Western Michigan	23-2026	Private	$ -	$ -	$ -	$ -	$	-
Mackinac Straits Hospital	23-1306	Public	$ 480,162	$ -	$ 5	$ -	$	480,157
Marlette Community Hospital	23-0082	Private	$ 57,521	$ -	$ 523	$ -	$	-
Marquette General Hospital	23-0054	Private	$ 5,910,132	$ 139,724	$ 81,573	$ 2,471,285	$	-
Mary Free Bed Hospital & Rehabilitation Center	23-3026	Private	$ 946,049	$ -	$ 2,023	$ -	$	-
McKenzie Memorial Hospital	23-1314	Private	$ 608,114	$ -	$ 3,071	$ -	$	-
McLaren Regional Medical Center	23-0141	Private	$ 12,062,221	$ 137,233	$ 43,947	$ 9,227,554	$	-
Mecosta County Medical Center	23-0093	Public	$ 1,997,232	$ -	$ 13,429	$ -	$	1,983,803
Memorial Healthcare	23-0121	Private	$ 2,263,195	$ 17,181	$ 19,818	$ -	$	-
Memorial Medical Center of West Michigan	23-0110	Private	$ 1,898,453	$ 166,644	$ 27,247	$ 1,196,554	$	-
Mercy General Health Partners	23-0004	Private	$ 10,210,282	$ -	$ 63,902	$ 2,377,686	$	-
Mercy Hospital - Cadillac	23-0081	Private	$ 2,930,125	$ -	$ 18,112	$ -	$	-
Mercy Hospital - Grayling	23-0058	Private	$ 3,002,333	$ -	$ 15,558	$ 1,196,554	$	-
Mercy Hospital - Port Huron	23-0031	Private	$ 3,979,138	$ -	$ 5,549	$ -	$	-
Mercy Memorial Hospital	23-0099	Private	$ 4,960,117	$ -	$ 14,511	$ 1,380,642	$	-
Metropolitan Hospital - Grand Rapids	23-0236	Private	$ 23,264,266	$ -	$ 37,333	$ 1,380,641	$	-
Mid Michigan Medical Center-Gladwin	23-1325	Private	$ 851,103	$ -	$ 2,458	$ 719,520	$	-
Mid Michigan Reg. Med. Ctr - Midland	23-0222	Private	$ 3,223,211	$ 142,188	$ 65,148	$ 2,655,729	$	-
Mid-Michigan Medical Center-Clare	23-0180	Private	$ 141,797	$ 47,345	$ 26,774	$ -	$	-
Mt. Clemens General Hospital	23-0227	Private	$ 17,946,609	$ -	$ 126,978	$ 6,212,887	$	-
Munising Memorial Hospital	23-1308	Private	$ 471,611	$ -	$ -	$ -	$	-
Munson Medical Center	23-0097	Private	$ 2,040,177	$ 55,976	$ 77,661	$ 1,656,656	$	-
North Oakland Medical Center	23-0013	Private	$ 12,561,526	$ 164,193	$ 109,378	$ -	$	-
North Ottawa Community Hospital	23-0174	Private	$ 4,973,520	$ 24,631	$ 2,007	$ -	$	-
Northern Michigan Hospitals, Inc.	23-0105	Private	$ 5,217,163	$ 21,815	$ 26,741	$ 1,877,111	$	-
Oakland Regional Hospital	23-3028	Private	$ 418,166	$ -	$ -	$ -	$	-
Oaklawn Hospital	23-0217	Private	$ 2,580,911	$ -	$ 7,407	$ -	$	-
Oakwood Annapolis Hospital	23-0142	Private	$ 3,343,795	$ -	$ -	$ -	$	-
Oakwood Heritage Hospital	23-0270	Private	$ 6,234,504	$ 245,634	$ -	$ -	$	-
Oakwood Hospital and Medical Center	23-0020	Private	$ 19,612,905	$ 35,986	$ -	$ 234,083	$	-
Oakwood Southshore Medical Center	23-0176	Private	$ 1,688,474	$ -	$ -	$ -	$	-
Ontonagon Memorial Hospital	23-1309	Public	$ 1,201,251	$ -	$ 201	$ -	$	1,201,050
Otsego County Memorial Hospital	23-0133	Private	$ 1,742,826	$ -	$ 4,797	$ 776,611	$	-
Paul Oliver Memorial Hospital	23-1300	Private	$ 336,222	$ -	$ -	$ -	$	-
Pennock Hospital	23-0040	Private	$ 1,642,683	$ -	$ 6,272	$ 922,835	$	-
Pine Rest Christian Hospital	23-4006	Private	$ 1,966,473	$ -	$ -	$ -	$	-
POH Medical Center	23-0207	Private	$ 17,370,113	$ 162,276	$ 55,167	$ -	$	-
Port Huron Hospital	23-0216	Private	$ 5,811,859	$ 75,656	$ 56,125	$ -	$	-
Portage Health Systems	23-0108	Private	$ 1,385,981	$ -	$ 5,350	$ 440,287	$	-
Providence Hospital	23-0019	Private	$ 18,556,323	$ 83,738	$ -	$ 741,883	$	-
Rehabilitation Institute	23-3027	Private	$ 5,910,148	$ 178,105	$ -	$ -	$	-
Rogers City Rehabilitation Hospital	23-3029	Private	$ (46,961)	$ -	$ -	$ -	$	-
Saint Mary's Standish Community Hospital	23-1305	Private	$ 249,960	$ -	$ -	$ -	$	-
SCCI Hospital - Detroit	23-2027	Private	$ 108,162	$ -	$ 200	$ -	$	-
Scheurer Hospital	23-1310	Private	$ 421,198	$ -	$ 309	$ -	$	-
Schoolcraft Memorial Hospital	23-1303	Public	$ 1,144,308	$ -	$ 589	$ -	$	1,143,719
Sheridan Community Hospital	23-1312	Private	$ 636,352	$ -	$ 1,549	$ -	$	-
Sinai-Grace Hospital	23-0024	Private	$ 45,612,670	$ 4,269,825	$ -	$ -	$	-
South Haven Community Hospital	23-0085	Public	$ 1,483,569	$ 48,954	$ 16,307	$ -	$	1,418,308
Southeast Michigan Surgical Hospital	23-0264	Private	$ 1,503,345	$ 2,277	$ 406	$ -	$	-
Southwest Regional Rehabilitation Hospital	23-3025	Private	$ (2,621)	$ -	$ -	$ -	$	-
Spectrum Health	23-0038	Private	$ 20,902,616	$ -	$ 411,233	$ 2,138,361	$	-
Spectrum Health - Kent Community Campus	23-2029	Private	$ 835	$ -	$ -	$ -	$	-
Spectrum Health - Reed City Campus	23-1323	Private	$ 556,368	$ -	$ 1,547	$ -	$	-
St. Francis Hospital	23-0101	Private	$ 4,726,684	$ -	$ 20,800	$ -	$	-
St. John - North Shores Hospital	23-0257	Private	$ 235,178	$ -	$ -	$ -	$	-
St. John Detroit Riverview Hospital	23-0119	Private	$ 27,378,185	$ 3,353,023	$ -	$ 1,206,149	$	-
St. John Hospital and Medical Center	23-0165	Private	$ 14,043,544	$ 170,518	$ -	$ 5,783,404	$	-
St. John Macomb Hospital	23-0195	Private	$ 7,557,618	$ 19,588	$ -	$ -	$	-
St. John Oakland Hospital	23-0223	Private	$ 6,748,982	$ 32,611	$ -	$ -	$	-
St. John River District Hospital	23-0241	Private	$ 689,980	$ -	$ -	$ -	$	-
St. Joseph Mercy Hospital - Ann Arbor	23-0156	Private	$ 17,886,609	$ -	$ 66,071	$ 9,380,834	$	-
St. Joseph Mercy Hospital & Health Services	23-0047	Private	$ 10,226,543	$ -	$ 7,166	$ -	$	-
St. Joseph Mercy Livingston Hospital	23-0069	Private	$ 1,237,711	$ -	$ 13,550	$ 1,087,790	$	-
St. Joseph Mercy Oakland	23-0029	Private	$ 13,874,881	$ -	$ 39,189	$ -	$	-
St. Joseph Mercy Saline Hospital	23-0212	Private	$ 498,323	$ -	$ -	$ -	$	-
St. Mary Mercy Hospital	23-0002	Private	$ 2,708,779	$ -	$ 5,557	$ -	$	-
St. Mary's Health Care (Grand Rapids)	23-0059	Private	$ 23,064,929	$ 129,447	$ 132,870	$ 1,678,688	$	-
St. Mary's Medical Center - Saginaw	23-0077	Private	$ 11,461,580	$ -	$ -	$ -	$	-
Straith Memorial Hospital	23-0071	Private	$ 6,894	$ -	$ -	$ -	$	-
Sturgis Memorial Hospital	23-0096	Public	$ 922,477	$ -	$ 10,701	$ -	$	911,776
Tawas St. Joseph Hospital	23-0100	Private	$ 2,024,379	$ -	$ -	$ 1,017,130	$	-
Three Rivers Area Hospital	23-0015	Public	$ 3,223,707	$ 11,010	$ 9,026	$ -	$	3,203,671
United Community Hospital	23-0293	Private	$ 3,130,444	$ -	$ -	$ -	$	-
United Memorial Health Center	23-0035	Private	$ 2,652,337	$ -	$ 9,950	$ -	$	-
University of Michigan Health System	23-0046	Public	$ 32,279,285	$ 101,740	$ 599,251	$ 60,102	$	31,518,192
W.A. Foote Memorial Hospital	23-0092	Private	$ 41,572,713	$ 19,431	$ 97,208	$ 1,530,530	$	-
West Branch Regional Medical Center	23-0095	Public	$ 1,745,664	$ -	$ 6,786	$ -	$	1,738,878
West Shore Medical Center	23-0060	Public	$ 2,296,223	$ -	$ 12,071	$ -	$	2,284,152
William Beaumont Hospital - Royal Oak	23-0130	Private	$ 44,030,826	$ -	$ 70,437	$ 324,760	$	-
William Beaumont Hospital - Troy	23-0269	Private	$ 3,993,538	$ -	$ 11,034	$ -	$	-
Zeeland Community Hospital	23-0003	Private	$ 931,424	$ -	$ 1,798	$ -	$	-
Subtotal - Hospital DSH Payments			$1,226,002,500	$ 45,000,000	$ 5,000,000	$ 172,343,362	$ 2,764,340	$ 74,065,875

State Psychiatric Hospitals	
Caro	$ 36,324,916
Kalamazoo	$ 31,560,019
Reuther	$ 37,986,760
Hawthorn	$ 2,014,030
Forensic Facility	$ 34,023,575
Subtotal - Sate Psychiatric Hospitals	$ 141,909,300

Summary of DSH Payments

Total IMD Payments:	**Actual**	**$ 141,909,300**
Total DSH Payments:		**$ 441,082,877**
	Over/(Under) Federal DSH Limit	
	Over/(Under) Federal IMD Limit	