May 25, 2010

Request for Proposals #MED10002

PROPOSAL TO PROVIDE
Disproportionate Share Hospital Program Audits

WEST VIRGINIA BUREAU FOR MEDICAL SERVICES

Technical Proposal
Electronic Copy

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TITLE PAGE (RFP Section 4.1)

RFP Title: West Virginia Disproportionate Share Hospital Program Audit Engagement

RFP Number: MED 10002

Name of Vendor: Clifton Gunderson LLP

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Authorized Contact: Mark Hilton, Partner

Email: Mark.Hilton@cliftoncpa.com

As a partner of the firm, I, Mark Hilton, am authorized to commit Clifton Gunderson LLP.*

Signature	Name	Title	Date
Mark K. Hilton	Mark K. Hilton	Partner	May 24, 2010

* Please see *Appendix A: Letter of Authority* for additional details

TRANSMITTAL LETTER (RFP Section 4.1)

May 25, 2010

Mr. Bryan Rosen
Office of Purchasing
West Virginia Department of Health and Human Resources
One Davis Square, Suite 100
Charleston, West Virginia 25301

Dear Mr. Rosen:

Clifton Gunderson LLP is very pleased to present this proposal to provide audits of Disproportionate Share Hospital (DSH) Payments for the West Virginia Department of Health and Human Resources, Bureau for Medical Services (Bureau or BMS).

Clifton Gunderson's West Virginia DSH Audit Team will afford you with insight and understanding that other firms simply cannot provide. Not only do our individuals have experience working together to serve Clifton Gunderson's state DSH clients across the nation, they have also served as CMS, state Medicaid, fiscal intermediary, and hospital leaders charged specifically with addressing the full spectrum of data, calculations, and regulations required for this audit. Further, members of your team have been actively engaged with CMS, Congressional staff, and state Medicaid leaders on DSH auditing since before Medicaid, Medicare, and Prescription Drug Act of 2003 (MMA) was adopted in November 2003. Not only do they have an unsurpassed understanding of the technical requirements, they also possess an unparalleled understanding of the communication process that will be required to afford you success in meeting the tight timeline for this effort.

At the mandatory pre-bid conference, it was indicated that the State of West Virginia was looking for a contractor that was ready to start the DSH auditing process without having to learn about DSH and auditing DSH hospitals. Clifton Gunderson is ready to perform these audits immediately, and needs no "ramp-up" time to start. Further, we do not propose any teaming arrangement or subcontractors. Rather, you will be served by a team of professionals that have a proven track record of working together to successfully address this complex audit process. Our familiarity with the DSH rules, CMS protocols, Hospital accounting records, State records, and the prior experience in presenting specific DSH auditing training programs to the hospitals and the State makes Clifton Gunderson the firm of choice to perform the required audits. Given that three years of DSH audits must be completed, delivered to you in draft, finalized, and then delivered to CMS in less than six months, we are confident that our value-driven, proven processes and staff will offer you compliance, insight, and value that simply cannot be replicated.

We have been conducting this work longer than any other firm in the Nation, as we were the first firm in the nation to be engaged by a state to audit pursuant to the Draft Rule (August 2005) and Final Rule (December 2008). Currently, we are engaged to provide DSH audit services to fifteen (15) Medicaid programs:

Alabama	Nevada	Tennessee
Arkansas	New Hampshire	Texas
District of Columbia	Oklahoma	Vermont
Michigan	Oregon	Virginia
Mississippi	South Carolina	Washington

Our Team Health Care (THC) staff focuses exclusively on contributing to the success of government health care providers. Further, our Office of Government services maintains an active, beneficial dialogue with Federal regulators, elected officials, and other health care leaders across the Nation. In the event that questions or unforeseen issues arise, we have the communication channels and reputation necessary to provide you with the most expedient resolution as we advocate for your interests. We were the only CPA firm in the Nation to engage CMS in the formal response period following the promulgation of the draft rule in 2005 and we have repeatedly met with CMS officials to seek clarification for clients, as each Medicaid program is unique and DSH operations in prior years were not contemporaneous with the specifics of the audit rule.

Members of your engagement team have previously met with State staff and your Hospital Association in order to explore the details of the audit regulation, its application to West Virginia, hospital data, and the details of your DSH program. Not only do we have demonstrated, unsurpassed proficiency regarding DSH audit requirements, we have an understanding of your specific program and our staffing, approach, and pricing reflects such. Further, your team will include individuals that were responsible for DSH operations and compliance in their previous capacities as senior CMS and state Medicaid leaders.

We are confident that our experience, methods, training and results are unparalleled within the government health care industry. Further, our ability to advocate for our clients in dealings with Federal regulators and our demonstrated success in facilitating positive outcomes is seconded only by our commitment to keep you well-informed and well-positioned in advance of any Federal audits.

Our proposal has been prepared in accordance with the instructions presented in this RFP. We have no conflicts and we have followed the formatting as required in *RFP Section 4 – Proposal Format and Response Requirements.* In addition, we confirm the following statements:

- ***RFP Terms:*** We accept all terms and conditions as outlined in the RFP.
- ***Pricing of Engagement:*** We certify that the price included in this proposal was arrived at without any conflict of interest.

If you would require any additional information or have questions concerning this proposal, contractual issues, or the execution of a contract, please contact me directly at 888-778-9588 (office) or via email at Mark.Hilton@cliftoncpa.com. We look forward to a long and mutually successful relationship with the West Virginia Department of Health and Human Resources, Bureau for Medical Services.

Sincerely,
CLIFTON GUNDERSON LLP

Mark K. Hilton

Mark K. Hilton, CPA
Partner

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RFP REQUIREMENTS CHECKLIST

RFP Requirements Checklist:
The RFP Requirements Checklist is a detailed listing of every general, technical, functional, staffing, and performance requirement.

- The Vendor is to crosswalk each RFP requirement to the site where it is addressed in its proposal (Columns B and C).

A		B	C
DSH RFP Requirements		Proposal Section	Proposal Page No.
	Vendor Responsibilities (Mandatory)		
3.1.1	**Issue an audit report that expresses an opinion on the six verifications established in the final rule and meets all requirements as set forth in 42 CFR 447 and 455.**	Section II *Engagement Standards (3.1.1)*	15
3.1.2	**Compile the eighteen data elements specified in the regulations for each hospital for each year audited and present that data in a separate schedule accompanying the audit report.**	Section II *Data Element Regulations (3.1.2)*	15
3.1.3	**Conduct the audit in accordance with generally accepted governmental audit standards as defined by the Comptroller General of the United States and the AICPA's Statements on Standards for Attestation Engagements (SSAEs).**	Section II *GAS Audit (3.1.3)*	16
3.1.4	**Meet the independence standards of governmental auditing standards as defined by the Comptroller General of the United States**	Section II *Independence (3.1.4 and 5)*	16
3.1.5	**Demonstrate independence from the Medicaid Agency and the hospitals they are to audit**	" "	" "
3.1.6	**Be a certified public accounting firm**	Section II *CPA Firm (3.1.6)*	16
3.1.7	**Agree to make all adjustments to audit procedures and report that impact the scope of the engagement upon future issuance of guidance by CMS, regardless of the timing of such issuance**	Section II: *Audit Adjustments (3.1.7)*	16
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3.1.9	**Provide the Department and applicable DSH hospitals an opportunity to provide written response to management letter comments**	Section II: *Management Letter (3.1.9)*	16
3.1.10	**Include Department responses in the bound report when it is issued**	Section II: *Bound Report (3.1.10)*	16
3.1.11	**Provide the Department with an electronic version of the final report and four (4) hard copies and one hard copy for each hospital included in the report on agreed**	Section II: *Electronic Version (3.1.11)*	16

A		B	C
DSH RFP Requirements		Proposal Section	Proposal Page No.
	upon dates.		
3.1.12	Provide all administrative, expert witness and other services necessary to represent the Department in the event of an audit, provider appeals or receipt of questions related to the work product of the Vendor. These services will be provided until all litigation claims and or audit findings are resolved with the Federal government regardless of whether the timing is within the contract period or after the contract period has expired	Section II *Testimony (3.1.12)*	16
3.1.13	Provide training and assistance to WV DSH hospital regarding DSH audit and reporting compliance at mutually agreed upon times and locations in accordance with submitted training plan.	Section II *Training (3.1.13)*	16
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"	Comprehensive profile of the CPA firm that includes a description of the management structure and ownership.	Section I *Business Organization*	4-14
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"	Provide a timeline or Gantt chart that demonstrates compliance with specified deadlines issued by CMS.	*Sec II: Timeline*	25-26
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EXECUTIVE SUMMARY

Our Understanding of Your Needs

The West Virginia Department of Health and Human Resources, Bureau for Medical Services (the Bureau or BMS) desires for the State of West Virginia to be in compliance with the Final Disproportionate Share Hospital (DSH) Audit Rule as published in the Federal Register December 19, 2008. Further, BMS wishes to have an examination performed on its hospitals that received DSH payments in Medicaid State Plan (MSP) years 2005 through 2009 as required by the Final DSH Rule issued by CMS. Examination procedures will also be performed at the State level to ensure compliance with specific verifications required by CMS. This audit will be used to prepare the West Virginia Annual DSH Reports to CMS as it relates to DSH payments made to West Virginia hospitals for MSP years 2005 through 2009. The Annual DSH Report will summarize hospital compliance with the Final DSH Rule and compare it with data on the State's DSH Reporting Schedule.

We have the experience, expertise and resources to accomplish each mandatory task outlined in the RFP. Further, as the DSH audit reports will be used by the Secretary of the Department of Health and Human Services (HHS) to reallocate future DSH allocations to states *(per health care reform legislation)*, we will not only ensure your compliance, we will contribute to your ability to provide the Secretary and others with valuable information to support future West Virginia allotments.

Our History with DSH

Even before the Medicare, Medicaid, and Prescription Drug Improvement Act (MMA 2003) added DSH audit requirements to the Social Security Act in November 2003, Clifton Gunderson's professionals were engaged in dialogue with CMS, the US Senate Finance Committee, and the US House Energy and Commerce Committee, and state Medicaid leaders regarding this matter. For six years we have been engaged in high-level, national efforts regarding the uninsured, under-insured, and complex efforts to address both.

Clifton Gunderson is at the forefront of the DSH requirements. We have spent the last four years developing effective DSH compliance procedures and working hands-on to prepare states for the DSH requirements. This practical experience has allowed us to develop comprehensive best practices, including the identification of key issues hospitals will face and the key issues that will impact states in complying with the Audit Rule.

When the final Rule was published, Clifton Gunderson immediately provided this information to Medicaid leaders across the Nation, issuing first an executive summary and then a comprehensive analysis at the request of current and prospective clients. We have been in constant communication explaining the requirements of the rule and in obtaining questions in order to seek clarification from CMS. No other firm in the country has been this involved in helping states with understanding and dealing with the requirements of the Rule.

Further, you CG team includes former CMS and state Medicaid leaders that have decades of experience in designing, operating, and auditing DSH programs.

Organizational Capacity

Clifton Gunderson is one of today's premier CPA and consulting firms. Founded in 1960, Clifton Gunderson has grown from a small, local firm

into one of the most robust CPA and consulting firms in the United States, with nearly 200 partners and more than 40 offices across the country.

We know that it takes a continuous effort to stay current on the latest issues and trends affecting Medicaid. We have approximately 150 staff, including seven Partners, who work full time with state Medicaid programs. The Clifton Gunderson health care team assigned to this project works exclusively "on the government side" and does not have distractions such as tax season and commercial clients. Our core team of hospital experts is nationally recognized for their insight and ability to effectively communicate on the complexities of DSH reimbursement and auditing. Our experts have repeatedly accepted invitations to educate National associations, industry groups, and elected officials regarding DSH.

Further, Clifton Gunderson maintains constant dialogue with CMS executives, key U.S. Senate/House committee members, state Medicaid officials, and industry leaders across the nation in order to provide our clients with guidance and assistance in a manner that other firms simply cannot match.

We have the resources to complete this engagement without the use of networks or subcontractors.

Experience with DSH

We were the first firm in the Nation to be engaged by a state (South Carolina) to audit pursuant to the Draft Rule (August 2005) and Final Rule (December 2008). We are currently engaged in 15 states: New Hampshire, Vermont, Texas, Mississippi, South Carolina, Nevada, Tennessee, Oklahoma, Washington, Alabama, Oregon, Virginia, Michigan, Arkansas, and the District of Columbia. Prior to the issuance of the Final Rule we audited uninsured data as part of DSH risk assessments and other hospital services for the states of Mississippi, Alabama, Nevada, Texas, South Carolina, North Dakota, Virginia, and North Carolina. Further, our Firm has been auditing hospitals on behalf of state Medicaid clients for more than 40 years. Our team includes former state officials and former CMS officials. Further, the fact that we have direct experience in auditing state agencies and state programs (including DSH), not just hospitals and other providers, positions Clifton Gunderson as uniquely qualified to exceed the requirements you have specified for this contract.

Clifton Gunderson was the only CPA firm in the Nation to formally engage CMS during the comment period following the promulgation of the draft rule. We have had an ongoing dialogue with CMS before, during and after the issuance of the final rule. Our overarching goal was to understand CMS's intent in issuing the rule and explore methods to carry out the requirements of the Rule in a manner that would provide the greatest value to our clients, reduce the risk of an audit by CMS or the OIG, and determine the least invasive process for state Medicaid agencies and hospitals. As a result, we have an in-depth understanding of the scope of work that CMS is requiring in the Rule and, although questions remain that require CMS to clarify certain aspects of the Rule, we can provide you with the assurance that the procedures we have developed and put forth in this proposal will meet the qualifications for full compliance with the Rule.

Plan of Operations

We have developed standard programs at the hospital and state level that will allow the State of West Virginia to comply with the DSH Audit

Rule (the procedures have been shared with CMS as a part of our on-going dialog). We will employ a mix of analytical procedures and substantive tests, performed both off-site (for all hospitals) and on-site (for state level), to address the verification areas outlined in the DSH Audit Rule. In addition, we will use a risk-based audit approach at the hospital level to ensure BMS receives maximum value for this contract.

Why Choose Clifton Gunderson?

We are confident that our extensive experience serving health care agencies, bolstered by our depth of resources and commitment to client service, make us the ideal candidate to serve you. A sampling of qualities that sets us apart from the competition includes:

- **Experience**. We have an unparalleled depth of experience providing creative solutions for today's complex Medicaid issues. Specifically, we have repeatedly demonstrated proficiency in providing state Medicaid clients with excellent service relating to each of the required elements outlined in the RFP. Our extensive knowledge of DSH and other health care regulatory issues affecting the States will result in more efficient procedures – saving you time and money. The members of your engagement team have repeatedly worked together to successfully address the complexities of the DSH audit requirements. We are not proposing to partner or subcontract with any other entity. Rather, we will provide you with a proven team of professionals.
- **Resources.** With over 150 experts dedicated to government health care compliance and over 1,800 additional professionals across the country, our extensive network of local and national resources will be available to provide you with exceptional depth in terms of specialized health care and governmental insight.
- **Understanding.** We are familiar with State DSH programs, including West Virginia's, and the specific challenges that the Final Rule presents, including, the very prescriptive language relating to the cost-to-charge ratios that must be used in a retrospective review of your hospital-specific calculations.
- **Commitment.** We seek a long-term relationship with BMS that will allow us to contribute to your ongoing success. Our Firm's more than 40 years of ongoing service to Medicaid clients, our relationships with Federal leaders, and our ongoing commitment to rigid internal training speak to our intent. We would be pleased and honored to build upon our ability to serve you and to be a part of your team.
- **Reputation.** Our reputation among state Medicaid leaders, regulators, and industry leaders is justifiably solid, our team is uniquely qualified, our expertise in the area is unparalleled, and we look forward to exceeding your expectations in a manner that will afford you with greater insight to manage the complexities of the Medicaid program.

SECTION I: BUSINESS ORGANIZATION/ VENDOR EXPERIENCE

BUSINESS ORGANIZATION

Vendor's Organization/Relevant Experience

Overview of Clifton Gunderson LLP
Clifton Gunderson, a Limited Liability Partnership, is one of today's premier CPA and consulting firms. Founded in 1960, Clifton Gunderson has grown from a small, local firm into one of the most robust CPA and consulting firms in the United States, with over 1,800 employees, including 197 partners, and more than 40 offices across the country.

Public sector clients, including state Medicaid agencies, account for a significant percentage of our firm-wide practice. We have demonstrated a strong commitment to our clients by providing creative solutions for today's complex Medicare and Medicaid issues. While BMS will enjoy the service of professionals who understand the issues critical to West Virginia, you will also have access to the knowledge and experience of our firm-wide Team Health Care (THC), our health care compliance team (which consists of approximately 150 FTEs), Governmental Services Team, and other professionals nationwide.

THC is Clifton Gunderson's niche practice dedicated to providing assurance, compliance and consulting services to government health care programs. These services include DSH and other eligibility projects for numerous state Medicaid agencies. This West Virginia DSH engagement fits perfectly for our THC practice.

Business Organization
Formed in 1960, Clifton Gunderson LLP is a limited liability partnership formed under the laws of the State of Delaware. Our corporate headquarters are located at:

10001 West Innovation Drive, Suite 201
Milwaukee, Wisconsin, 53226-4851

Prior to becoming Clifton Gunderson LLP, the firm has also done business under the following names: Clifton Gunderson & Co. (Illinois General Partnership), Clifton Gunderson L.L.C (Illinois Limited Liability Company), and Clifton Gunderson L.L.C (Delaware Limited Liability Company).

Clifton Gunderson is not a subsidiary of any larger company or otherwise related company. As a limited liability partnership, Clifton Gunderson is wholly owned by its partners and governed by its partnership board consisting of nine internal partners elected by their peer professionals.

We have included our firm-wide organizational chart *Appendix B: Organizational Chart*.

Office Location
Clifton Gunderson is separated into reporting units called Client Service Centers. Our Baltimore, Maryland office, from which the bulk of the West Virginia DSH work will be performed, is part of the Mid-Atlantic Client Service Center (MACSC). In addition to the Baltimore office, the MACSC includes offices in Raleigh, North Carolina; Arlington, Virginia; Washington, D.C.; and Richmond, Virginia. Within the MACSC, THC practices reside in our Raleigh, Richmond, and Baltimore offices.

Peer Review
We are a licensed Certified Public Accounting firm. As such, we receive an external quality control review every three years, and have received an unqualified opinion every year in

which we have undergone an external quality (peer) review.

The Public Companies Accounting Oversight Board (PCAOB) conducts inspections of the firm's procedures relating to audits of public companies, while the remainder of a firm's practice is peer reviewed under AICPA guidelines. We will continue to have an unrelated certified public accounting firm perform an extensive peer review of our quality control policies and procedures every three years under these guidelines. We have included a copy of our most recent peer review report, dated December 19, 2007, in *Appendix C: Peer Review Report.*

In addition to our external peer review, we have undertaken an intensive Internal Quality Control Program to assure that the highest standards are maintained in our work. This program is designed to provide reasonable assurance that our personnel will be competent, objective and will exercise due professional care. Included in that program are the following:

- We have developed a quality control manual to dictate the quality control standards and policies of our firm. These standards often exceed requirements set forth by professional standards and governmental guidelines. To monitor the adherence to policies and procedures, and to assure the quality and accuracy of services provided meet our high standard of client services, each office must have a regular internal examination performed by professionals from other firm offices.
- All professional staff are required to obtain at least 40 hours of continuing education every calendar year. This requirement exceeds the requirements of some state CPA licensing boards. In addition, our health care staff completes health care specific training as part of the 40 hours from both internal and external programs.

Expertise in Health Care Compliance

Clifton Gunderson has served health care regulatory and enforcement agencies and worked with Medicare and Medicaid agencies for more than 40 years. Our experience in providing health care assurance and consulting services to state Medicaid programs, Medicare, and the Department of Justice is unrivaled. We, as a firm, have performed full and limited scope audits (including DSH), claim reviews, cost settlements, and rate setting for just about every provider type in numerous states. We have represented Medicaid and Medicare at various levels of appeals throughout the country, and we have assisted the Department of Justice and state Medicaid Fraud Control Units in both civil and criminal actions related to health care fraud. Additionally, we have provided health care consulting services to multiple State and Federal clients.

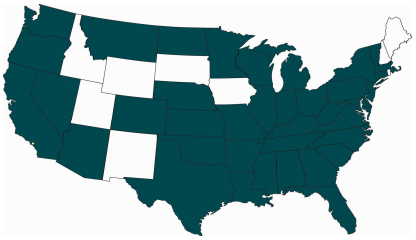
Clifton Gunderson has served health care regulatory and enforcement agencies and worked with Medicare and Medicaid agencies for more than 40 years.

Nationally recognized as experts in the area of health care audit, compliance and consulting, we currently service health care audit, compliance, and consulting contracts with the states of Texas, Mississippi, Alabama, Virginia, South Carolina, Michigan, Maryland, North Dakota, Massachusetts, New Hampshire, Arkansas, Oregon, Washington, Oklahoma and Nevada. In addition, we have provided compliance-related services in the past to the states of Indiana, North Carolina, Ohio, Illinois, Wisconsin, Kentucky, Nebraska, Georgia, New Mexico, Tennessee, Colorado and Montana.

At the Federal level, Clifton Gunderson provides audit and consulting services to HHS and the

CMS, and provides health care related litigation support services to the U.S. Department of Justice (DOJ) and the Federal Bureau of Investigation.

The shaded areas on the map below illustrate the locations of Clifton Gunderson's current and past health care audit and consulting engagements across the United States.



We were founded and continue to operate on the principles of "extraordinary client service" and an "unwavering commitment to quality." Firm-wide, our health care partners and staff work full time serving our Medicaid and Medicare agency clients with the majority of our work being for state Medicaid programs. Clifton Gunderson's health care compliance team is highly regarded for its professional objectivity, innovation, quality people, and unparalleled service. Our success has been achieved by providing our clients with excellent service on a timely basis, including those times when clients have made urgent requests with minimal turn-around time. Unparalleled service requires commitment and an understanding of the client's needs and then fulfilling those needs in an effective and economical manner. We are committed to servicing the State of West Virginia as efficiently and economically as possible while maintaining the highest levels of quality and service.

In addition, Clifton Gunderson affords every client the benefit of direct communication with high-level regulators and policy makers throughout the nation. This value-added service enables us to provide clients with unparalleled access, timely insight, and the benefit of solid relationships that have been built through years of professional dialogue and successful service. This collaboration is just one example of the comprehensive, full-service, client-focused approach that our firm takes in order to surpass our competitors and to contribute to the ongoing success of each client.

Clifton Gunderson's commitment to quality, superior work ethic, and excellent track record with State Medicaid Programs are just a few of the reasons that we are the logical choice to provide DSH audit services to BMS. Our success has been achieved by providing our clients with excellent service on a timely basis. Unparalleled service requires commitment and an understanding of the client's needs, and then fulfilling those needs in an effective and economical manner. We are committed to servicing the State of West Virginia as efficiently and economically as possible while maintaining the highest levels of quality and service. Specifically, Clifton Gunderson meets the experience requirements outlined in the RFP in the following ways:

- We have significant DSH audit experience from our work in other States including not only the audit of DSH hospitals, but also direct, unique experience auditing and assessing state compliance with all applicable DSH regulations and limits.
- Our Medicaid auditing staff understands the DSH rule and how to work with the providers in a professional and positive manner.
- We have more than 60 years of combined firm experience servicing and enhancing Medicaid-related contracts across the country including state-wide Medicaid audit contracts in six states – North Carolina, Virginia, Mississippi, Indiana, Maryland and Ohio.

Medicaid Audit and Consulting Experience

Overview
Throughout Clifton Gunderson's 40 years of managing Medicaid audit, compliance, and consulting contracts, we have performed a wide variety of services for our state Medicaid agency clients including:

- DSH audits and reviews
- Full and limited scope Medicaid cost report audits of acute care hospitals, psychiatric hospitals, nursing facilities, ICFs/MR, home health agencies, federally qualified health center (FQHC), and rural health centers (RHC)
- Medicaid compliance audits (both full and limited scope reviews)
- Establishment of rates/rate recalculations
- Medicaid policy consulting
- Cost settlements
- Claim/billing reviews
- Representation of states before CMS, DOJ, and OIG
- Medicaid performance audits and consulting engagements
- Assistance with CMS and OIG audit findings
- MMIS audits
- Expert witness testimony
- Appeal assistance
- Eligibility Payment Error Rate Measurement (PERM) activities
- CMS 64 – Quarterly Expense Report reviews
- State plan amendment assistance

One of Clifton Gunderson's key strengths in the Medicaid audit compliance arena is our conscious choice to represent Medicaid and Medicare Programs and not to seek out or represent providers. This approach allows us to avoid conflicts of interest and also to gain a deep understanding and appreciation of the regulators' and intermediaries' sides of the reimbursement equation.

DSH Audit and Consulting Experience
Clifton Gunderson is at the forefront of the DSH audit requirements. Since the issuance of the Draft Rule in 2005, we have been developing effective DSH compliance procedures, and working hands-on to prepare states for the DSH changes before the Final Rule was issued. During that time, we have learned that many states are not only insufficiently prepared for the impending DSH changes but many do not fully understand the dramatic impact they may have on state budgets. This practical experience has allowed us to develop comprehensive best practices, including the identification of key issues for hospitals that are overdue for an audit, and the identification of key issues that will impact states in complying with the Final Rule.

Our unique experience and qualifications allow us to provide BMS with unparalleled service on matters related to DSH. In fact, our DSH audit efforts on behalf of state Medicaid clients position us with the unique experience, proven audit programs, and trained government health care professionals to assist you with this high-profile, complex reimbursement process. Our core team of hospital experts is nationally recognized for their insight and ability to effectively communicate on the complexities of DSH reimbursement and auditing. Our experts have repeatedly presented on DSH at venues such as the Annual HSFO Conference including this summer's conference in New Orleans. Further, no firm in the nation possesses our experience in providing states with independent audits and assessments of their DSH programs.

We were the first CPA firm in the nation to conduct an "independent audit of a state DSH program". We have included the State of South Carolina as a reference specifically capable of addressing our audit experience pursuant to

Section 1923(j)(A-E) of the Social Security Act, as our South Carolina audit contract has included such requirements since 2006.

The proposed key personnel including Mark Hilton, partner and John Kraft, senior manager have arguably the most significant direct experience in the country in performing an actual DSH audit of a state and its implications on the hospitals in that state. We already know what a State will encounter with the audit and what the hospital concerns are with the new documentation requirements. The rest of the Clifton Gunderson team, including associate level auditors have direct experience with auditing DSH programs and hospitals.

The following descriptions provide a brief overview of our relevant DSH experience. All of these contracts and engagements have been completed successfully or are on-going. Also refer to *Appendix D: Project Profiles* for more detailed information regarding these engagements. We encourage you to contact our clients. They will speak to our experience, professionalism, timeliness, and quality client service.

South Carolina Department of Health and Human Services

For the State of South Carolina, Clifton Gunderson performs an independent audit of their DSH program. This engagement originally followed the guidelines established in the August 2005 proposed DSH Audit Rule. Contract terms, scope, and reporting have been refined to adhere to additional guidance and best practices over the past four years. Specifically, South Carolina currently has 70 hospitals receiving DSH payments under this Medicaid methodology. Clifton Gunderson validates the data on a hospital-specific basis in order to assess compliance with applicable federal and state regulations. We provide testing procedures at two levels - hospital desk verification and state verification. We also assess State policies and procedures to report on compliance with all applicable rules and regulations. Draft reports for 2005 and 2006 DSH audits have been completed.

Alabama Medicaid Agency

For Alabama Medicaid, we have been engaged to perform the 2005 through 2011 DSH audits of the State of Alabama. Prior to this, we were engaged to perform the State's Certified Public Expenditure (CPE) settlements for 2006, which include a detailed analysis of Medicaid shortfalls and the unreimbursed cost of care for uninsured individuals, which were used to claim FFP. Draft reports for the 2005 and 2006 DSH audits have been completed.

Mississippi Division of Medicaid

For the Mississippi Division of Medicaid, we have been engaged to perform the 2005, 2006, 2007, and 2008 DSH audits. In addition, we have been engaged to perform an analysis of the state's DSH program in accordance with the Final Rule as promulgated by CMS on December 19, 2008. Previously, we performed a review of DSH calculations, policies, and procedures as performed by the Mississippi Hospital Association on behalf of the Division of Medicaid. That engagement also included a review of DSH policies and procedures performed at the State level. Moreover, we continue to assist the State in developing a comprehensive plan to maximize DSH and Upper Payment Limit (UPL) reimbursement in a compliant manner. That project also includes an extensive on-going examination of hospital-specific uninsured charges and payments for compliance with current and proposed regulations. Draft reports for the 2005 and 2006 DSH audits have been completed.

Nevada Department of Health and Human Services
For the State of Nevada, we have been engaged to perform the 2005, 2006, and 2007 DSH audits. Nevada was among the first states in the Nation to meet the CMS original deadline of December 31, 2009, for the submission of the first two DSH audit years. Clifton Gunderson has also provided risk assessment and operational compliance assessment services for its DSH program. Specifically, Clifton Gunderson performs an analysis of the Department's current rules, policies and procedures, including the State Plan under Title XIX of the Social Security Act, an assessment of the risk of non-compliance with current and proposed DSH rules promulgated by CMS, an assessment of the risk that the State's current DSH program operational practices do not ensure compliance with the established policies and procedures, and an analysis and assessment of the risk that the underlying hospital cost data submitted to the Department may not be reliable. Final submission of the 2005 and 2006 DSH audits has been made to CMS.

Virginia Department of Medical Assistance Services
We performed audits of the multi-settlement cost reports for the Virginia state teaching hospitals. The multi-settlement cost report is used to determine the cost of uncompensated care provided to Medicaid Health Maintenance Organization (HMO) patients, indigent patients as defined by the State, uninsured patients based on the Federal definition, and physician's costs of providing care to these groups of patients. We are currently performing DSH audit procedures on all Virginia DSH hospitals for 2005 and 2006.

North Dakota Department of Human Services
For the State of North Dakota, Clifton Gunderson conducted a review of North Dakota's DSH program to verify DSH payments were in compliance with the State Plan and Federal laws and regulations. Steps included review of the State's calculations for individual hospitals, review of supporting uninsured charges and payments from hospitals, calculation of hospital specific DSH limits, and UPL calculations.

Oklahoma Health Care Authority
Clifton Gunderson has been retained by the State of Oklahoma to perform the DSH audits for state plan rate years 2005, 2006, 2007, and 2008. Draft reports for the 2005 and 2006 DSH audits have been completed.

Washington Department of Social and Health Services
Clifton Gunderson has been retained by the State of Washington to perform the DSH audits for state plan rate years 2005, 2006, and 2007. The State has submitted 2005 and 2006 reports to CMS.

New Hampshire Department of Health and Human Services
Clifton Gunderson has been retained by the State of New Hampshire to perform the DSH audits for state plan rate years 2005 through 2008.

State of Oregon Department of Human Services
Clifton Gunderson has been retained by the State of Oregon to perform the DSH audits for state plan rate years 2005 through 2008 with an option for 2 additional years.

State of Arkansas Department of Human Services
Clifton Gunderson has been retained by the State of Arkansas to perform the DSH audits for state plan rate years 2005 through 2012.

State of Michigan Department of Community Health
Clifton Gunderson has been retained by the State of Michigan to perform the DSH audits for state plan rate years 2005 through 2012. Draft reports for 2005 and 2006 have been completed.

State of Vermont Department of Human Services
Clifton Gunderson has recently been retained by the State of Vermont to perform the DSH audits for state plan rate years 2005 through 2008.

Texas Health and Human Services Commission
We have recently been retained by the State of Texas to perform the DSH audits for 2005, 2006, and 2007. In addition, Clifton Gunderson has provided an on-going risk assessment and audit review of the State's DSH program. Specifically, we identified program vulnerabilities by conducting a risk assessment of the DSH program followed by agreed-upon audits at selected statewide hospitals.

State of Tennessee:
The State of Tennessee did not make DSH payments for 2005 and 2006, as their TennCare waiver included all DSH funds. We have recently been awarded a contract to audit 2007 through 2009 DSH years for the State. Further, we will conduct a study of the percentage of cost reimbursed to all hospitals in the state through Medicaid managed care and fee-for-service programs, which will follow-up on similar reports issued for 2006 and 2007.

References
Quality of service will be a key factor as you prepare to select a CPA and consulting firm to serve BMS. We encourage you to contact the following client references, all of which are CPAs, to learn more about our experience and commitment to quality client service. In addition, following this section, we have included letters of reference from the following agencies for which we perform DSH work.

- *South Carolina Department of Health and Human Services*
  Mr. William Wells, CPA, Deputy Director, Finance and Administration
  1801 Main Street, Room 633
  Columbia, South Carolina 29201
  803-898-1058
  wells@dhhs.state.sc.us

- *Mississippi Division of Medicaid*
  Ms. Janet Mann, CPA, Deputy Administrator
  Walter Sillers Building
  550 High Street, Suite 1000
  Jackson, Mississippi 39201
  601-209-7033
  janet.mann@medicaid.ms.gov

- *Alabama Medicaid Agency*
  Mr. Rob Church, CPA, CFO
  501 Dexter Avenue
  P.O, Box 5624
  Montgomery, Alabama 36103-5624
  334-242-5600
  rob.church@medicaid.alabama.gov

State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Emma Forkner
Director

July 31, 2009

Dear Sir/Madam:

I am writing on behalf of the South Carolina Department of Health and Human Services to offer a professional reference for Clifton Gunderson LLP.

Clifton Gunderson has served the South Carolina Department of Health and Human Services since 2006. We initially employed Clifton Gunderson to perform audits of our South Carolina Medicaid Disproportionate Share Program in accordance with the Proposed Rule issued by CMS in the August 26, 2005 Federal Register. Next, because South Carolina employs a retrospective reimbursement system for SC general acute care hospitals, we added cost report audits to their responsibilities since we did not feel that the Medicare audits met our needs. Now that the final rule has been issued by CMS in regards to the Medicaid DSH audits, we have directed Clifton Gunderson to perform audits of the FY 2005 and FY 2006 South Carolina Medicaid DSH Program in accordance with the instructions of the final rule.

Through their efforts, Clifton Gunderson has assisted the State in getting hospitals ready for the Medicaid DSH audits as required by the final rule. It is anticipated that as a result of the DSH audits, there will be more uniform reporting of data by the hospitals. The cost report audits that Clifton Gunderson will perform will ensure that South Carolina Medicaid is reimbursing hospitals their total allowable Medicaid costs.

We are very pleased with our partnership with Clifton Gunderson. Staff members of the South Carolina Hospital Association have also been very appreciative of Clifton Gunderson's assistance in providing information and clarification to its members regarding the final rule relating to the Medicaid DSH audit requirements.

Sincerely,

Jeff Saxon
Bureau Chief, Reimbursement Methodology and Policy
(803) 898-1023; saxon@scdhhs.gov

Bureau of Reimbursement Methodology and Policy
P. O. Box 8206 Columbia South Carolina 29202-8206
(803) 898-1040 Fax (803) 255-8228

STATE OF MISSISSIPPI

OFFICE OF THE GOVERNOR
DIVISION OF MEDICAID
DR. ROBERT L. ROBINSON
EXECUTIVE DIRECTOR

Ladies and Gentlemen:

I am very pleased to extend this professional reference for Clifton Gunderson LLP. I have personally worked with Clifton Gunderson since 2006 in my capacity as Deputy Administrator.

The State of Mississippi, Office of the Governor, Division of Medicaid (Division) retained the services of Clifton Gunderson to provide audit and consulting services to the Division since 2006. Since that time, Clifton Gunderson has performed cost report audits of hospitals, nursing facilities, and State-owned and private ICF/MR providers and performed billing/claim audits of hospitals, psychiatric service providers, and therapy providers. In addition, Clifton Gunderson has also been engaged to provide performance evaluations of the Mississippi State Children's Health Insurance Program (SCHIP), the Medicaid Management Information System (MMIS), the Medicaid Supplemental Drug Rebate Program, and the Disproportionate Share Hospital (DSH) and Upper Payment Limit (UPL) programs. Clifton Gunderson is also performing the eligibility portion of the Payment Error Rate Measurement (PERM) project and provides assistance with proposed CMS regulations and various issues before CMS.

Through their efforts, Clifton Gunderson has saved the State over $200 million. In addition, they have provided invaluable assistance in bringing the provider community into compliance with State and Federal laws and regulations. With ever tightening budgets and ever increasing Federal oversight, Clifton Gunderson's nationwide resources and experience have been invaluable as we work to provide the best health care to low income Mississippians.

I am very proud of our relationship with Clifton Gunderson. They understand the complexities of Medicaid and the issues we face. As a CPA, I can personally attest to their responsiveness, quality, dedication to detail, and timeliness.

I would recommend them without hesitation to any state. Should you have any questions, please give me a call at (601) 359-6528 or EXJHM@medicaid.state.ms.us.

Sincerely,

Janet H. Mann, CPA
Deputy Administrator of Audit & Recovery

Suite 1000, Walter Sillers Building, 550 High Street, Jackson, MS 39201, (601) 359-6050

Alabama Medicaid Agency

501 Dexter Avenue
P.O. Box 5624
Montgomery, Alabama 36103-5624

www.medicaid.alabama.gov
e-mail: almedicaid@medicaid.alabama.gov
Telecommunication for the Deaf: 1-800-253-0799
334-242-5000 1-800-362-1504

BOB RILEY
Governor

CAROL H. STECKEL, MPH
Commissioner

July 27, 2009

Dear Sir/Madam:

I am writing on behalf of the State of Alabama and the Alabama Medicaid Agency in order to provide a professional reference for Clifton Gunderson LLP.

I have known Dave Mosley, partner and assistant director of government services, in a professional capacity for five years. Clifton Gunderson has served as a professional contractor to the State of Alabama's Medicaid program for the past three years.

Clifton Gunderson's services to the State of Alabama have included, but not been limited to, the following services pursuant to federal requirements for (1.) hospital CPE settlement and (2.) hospital DSH auditing:

1. Analysis of hospital-specific charges reported by hospitals as being on behalf of uninsured individuals
2. Determination of hospital-specific profit/(loss) attributable to serving Medicaid beneficiaries
3. Collection, review, and adjustments to the Medicaire 2552-96 cost report (Medicare Cost Report) pursuant to Federal CPE and DSH audit requirements
4. Working with hospitals, the Alabama Hospital Assocaition, and the State in order to generate required reports capturing a myriad of payment and claims data
5. Meeting with the State's Governor, State's Finance Director, outside counsel, and others in concert with Medicaid professional staff in order to address information and strategy
6. Facilitating meetings with CMS and both representing the State in such meetings and attending such meetings with the State as its agent
7. Providing training to hospitals, the hospital assocaition, and State staff relating to the detailed requirements (methods and data) for CPE settlement and DSH auditing
8. Responding to individual hospitals' requests relating to specific data issues
9. Facilitating and participating in meetings between the State and Alabama hospitals
10. Evaluating complex taxation, assessment, and reimbursement models prepared by outside entities and submitted to the Governor and the Agency

Clifton Gunderson's professionals have provided excellent service to the State of Alabama in a manner that has met, or exceeded, our expectations. They have repeatedly demonstrated that they possess the education, experience, and motivation to serve us very well.

Our Mission - to provide a system of financing health care for eligible Alabamians in accordance with established statutes and Executive Orders.

In my role as a Board member and program committee member with the National Association of Human Service Finance Officers (HSFO), I have called upon Dave and his colleagues to assist in providing continuing professional education (CPE) to our members on DSH auditing (3 yrs), Title IV-E auditing, hospital reimbursement, and ethics.

Further, Clifton Gunderson's well-earned reputation among regulators (specifically CMS), politicians, states, and leaders across the Nation have afforded with the opportunity to garner important feedback, insight, information, and meetings that continue to benefit our efforts to serve the State of Alabama.

Should you have any specific questions, or require additional information, please do not hesitate to contact me at (334) 242-2301.

Sincerely,

Terry G. Bryant, CFO
Alabama Medicaid Agency

SECTION II: UNDERSTANDING OF PROJECT OBJECTIVES AND TIMELINES

PROJECT APROACH AND SOLUTION

Mandatory Requirements *(RFP Section 3.1)*

Engagement Standards (RFP Section 3.1.1)
Our approach is to provide BMS with the highest level of assurance required by the DSH Audit Rule in an economic manner. In order to do so, the audit will need to be conducted under the appropriate standards to allow for an opinion to be expressed on the verifications identified in the Rule.

The Audit Rule states "the nature of the audit encompasses both program and financial elements making it impossible to label as a traditional financial or programmatic/ governmental audit." In addition, 45 CFR Section 455.301 states "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." The discussion accompanying the Rule states "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. Attestation engagements may take a narrower focus (less than full program review) and, therefore, more directly fit with the scope of the DSH audit and reporting requirements.

As the discussion accompanying the Rule points out, GAGAS also provides standards for the conduct of attestation engagements. There are three types of attestation engagements: examinations, reviews and agreed-upon procedures. An examination consists of obtaining sufficient and appropriate evidence to express an opinion on whether the subject matter is based on, or conforms to, criteria in all material respects or whether an assertion is presented or fairly stated. A review consists of sufficient testing to express a conclusion about whether any information came to the auditor's attention that indicates that the subject matter is not based or in conformity with criteria or is not fairly represented. An agreed-upon procedure engagement consists of specific procedures, agreed to by the client, which is performed on a subject matter.

The discussion in the rule indicates attestation engagements under GAGAS incorporate other standards, specifically the AICPA's Statements on Standards for Attestation Engagements (SSAE). We have reviewed the SSAE as it would apply to the requirements of the Rule and have concluded they would not expand the scope of work needed to be performed to comply with the Rule. Although it is not the only approach that can be applied, we propose to conduct this work as an examination as it would be the most appropriate report to meet the requirements of the Rule and the specific needs of BMS.

An added benefit of performing this work as an examination is that GAGAS requires the audit report to include any significant deficiencies in internal control or material weaknesses in the program. This will provide BMS with useful information to improve controls within the DSH program.

Although it may be suggested by other bidders that an Audit or a Performance Audit is necessary to reduce the State's risk of Federal scrutiny, this assertion is not correct.

Data Element Regulations (RFP Section 3.1.2)
We will compile the 18 data elements specified in the DSH regulations for each hospital for year audited. We will present that data in a separate

schedule accompanying the audit report. Please see *Project Plan: State Requirements* on page 18 for additional details

GAS Audit (RFP Section 3.1.3)
We will conduct the audit in accordance with generally accepted governmental audit standards as defined by the Comptroller General of the United States and the AICPA's Statements on Standards for Attestation Engagements (SSAEs).

Independence (RFP Section 3.1.4 and 3.1.5)
Since 2005 we have not, through direct or indirect methods, provided services to any non-State owned or operated provider facilities or facilities previously enrolled in the Illinois Medicaid program which could potentially be subject to DSH audit or review by BMS.

We have no ownership interest and not have held any ownership interest in any entity currently enrolled in the West Virginia Medicaid program or any entity which was enrolled in the West Virginia Medicaid program.

Should a conflict arise, Clifton Gunderson will first determine if there is any independence impairment under AICPA independence rules. We will also notify BMS of any work performed for a hospital receiving DSH funds. Should an independence impairment or conflict arise, we will subcontract that work to another accounting firm, so as not to conflict with the DSH audit.

Certified Public Accounting Firm (RFP Section 3.1.6)
Clifton Gunderson is a Certified Public Accounting firm licensed in the State of West Virginia. Please see *Appendix E: Licensing Information* for additional details.

Audit Adjustments (RFP Section 3.1.7)
We agree to make all adjustments to audit procedures and reports that impact the scope of the engagement upon future issuance of guidance by CMS, regardless of the timing of the issuance.

Exit Conference (RFP Section 3.1.8)
We will conduct an exit conference with the Department representatives once a preliminary, typed draft of the required engagement report have been accepted by the Department.

Written Response to Management Letter Comments (RFP Section 3.1.9)
We will provide BMS and applicable DSH hospitals the opportunity to provide written responses to the management letter comments.

Bound Report (RFP Section 3.1.10)
We will issue a bound report containing the Department's responses.

Electronic Version (RFP Section 3.1.11)
We will provide BMS with am electronic version of the final report, as well as four hard copies. In addition, we will provide a hard copy for each hospital included in the report. We will issues these copies in a timely manner based on agreed upon dates.

Testimony (RFP Section 3.1.12)
Should the need arise for any administrative, expert witness, or other services, we will represent the Department. This includes providing services in the event of an audit, provider appeals, or receipt of questions related to our work. We will provide these services until all litigation, claims and/or audit findings are resolved with the Federal government regardless of whether our contract period has expired.

Training (RFP Section 3.1.11)
We will provide training and assistance to West Virginia DSH hospitals regarding the DSH audit and reporting compliance at mutually agreed upon times and locations. Please see *Proposal Section Training* on page 24 for additional details.

Scope of Work *(RFP Section 3.2)*

Understanding of Project Objectives and Timelines

We further understand the audit performed by Clifton Gunderson will be submitted by the State of West Virginia in accordance with Section 1923(j)(2) of the Social Security Act (the Act) to the Secretary of Health and Human Services. The audit will certify the following verifications outlined in the Social Security Act:

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.

We understand and agree with all project objectives and timelines. We will cooperate with the State in this monitoring activity, which may require that Clifton Gunderson report progress and problems (with proposed resolutions), provide records of its performance, allow random inspections of its facilities, participate in scheduled meetings and provide management reports as requested by the State.

We have met all requirements and deadlines for our current fifteen (15) DSH audit contracts.

Understanding of Overall Project

We understand that BMS is seeking independent certified public accounting firms to develop and conduct annual engagements of the West Virginia Disproportionate Share Hospital Program that will meet the requirements described in 42 CFR Part 447 and 455.

The engagements will be conducted in accordance with the American Institute of Certified Public Accountants (AICPA) Statements on Standards for Attestation Engagements (SSAEs) and generally accepted government auditing standards as defined by the Comptroller General of the United States.

Detailed Audit Work Plan

Our project plan is designed to meet CMS's reporting and verification requirements in the most efficient and effective manner possible within the parameters of the applicable auditing standards. Our procedures are designed to be sufficiently flexible should CMS issue further clarifications or guidelines on the type of engagement or standards to be used for the implementation of the Rule.

In order to express an opinion on the verification areas outlined in the DSH Audit Rule, we will perform a mix of analytical procedures and substantive tests at both the State and hospital levels using a risk-based approach. Engagement risk arises from a number of factors including complexity of the program, sensitivity of the

work, size of the program, the auditor's access to records, and the adequacy of the audited entity's systems and processes to detect inconsistencies, significant errors or fraud. GAGAS recognizes the existence of engagement risk and allows for auditors to make adjustments to procedures to address these risks. We describe our risk-based approach in greater detail later in this section.

We will provide you, our client, with continuous communication throughout the audit process. In addition to the entrance and exit conferences, we will hold intermittent status meetings to discuss the detailed project plan and our progress towards completion. Further, we will be available to answer any questions and address any concerns during the course of the examination.

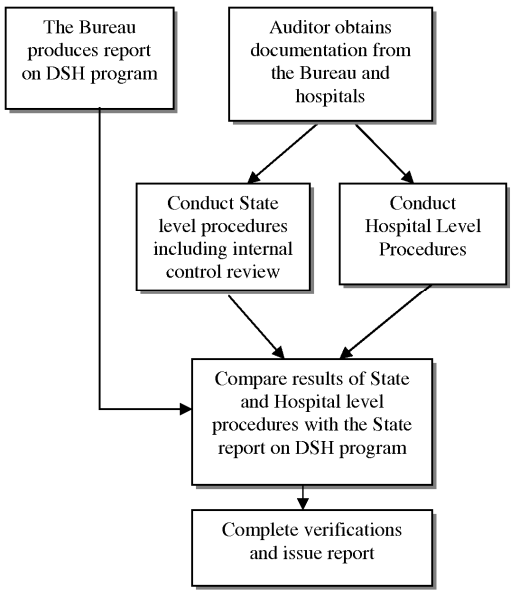
It is equally important to maintain open lines of communications with the hospitals. The hospitals must be provided with direction on the audit process and the specific information they will be asked to submit. They must also be afforded an avenue to have their questions answered. As such, we recommend hosting one or more training sessions for hospital representatives very early in the process.

To provide an added level of assurance that our procedures and training materials meet the vision of what CMS intended under the final rule, we have retained the services of Mr. Jim Frizzera of Healthcare Management Associates (HMA) to review these documents. Please see *Appendix F: Frizzera Email* for his comments.

Prior to joining HMA in December 2008, Mr. Frizzera worked at CMS for the last 20 years. Most recently, his responsibilities included the overall financial management of the $300+ billion Medicaid program. Mr. Frizzera oversaw federal Medicaid grant outlays, State budget and expenditure reporting, national Medicaid reimbursement policy, and State Medicaid financing policy. He was instrumental in developing the final DSH audit rule. Mr. Frizzera is recognized as a national expert in the area of Medicaid reimbursement and financing, including Medicaid DSH payments, Medicaid UPLs, health care-related taxes, provider-related donations, intergovernmental transfers, and certified public expenditures. In his opinion, our procedures and documents meet the requirements of the final rule as envisioned by CMS. While we are cognizant of the fact that CMS can revise their interpretation of the DSH rule at any time, we can afford BMS a higher level of assurance of the propriety of our procedures and training material than any other CPA firm proposing on this RFP.

> "Your Firm's approach to addressing the Medicaid DSH audit requirements should provide the Federal government, State governments, and hospitals with a new level of transparency and insight into the effective management of comprehensive hospital reimbursement efforts."
>
> *Jim Frizzera, Principal*
> *Health Management Associates*
> *(former CMS Director and contributor to DSH Rule)*

The following chart illustrates our approach to conducting the DSH examination.



State Reporting Requirements

Under 42 CFR Section 447.299, States are required to submit to CMS, at the same time as it submits the completed audit required under Section 455.304, 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 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 examination 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 Number 5 below.
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 Number 5 below.
5. *State defined DSH qualification*. 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 Numbers 6, 7, and 8.
10. *Total Cost of Care for Medicaid IP/OP Services*. The total annual cost 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 Number 9 from the amount identified in Number 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 Numbers 12 and 13 from Number 14.
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 Numbers 9, 12, and 13 subtracted from the sum of Numbers 10 and 14.
17. *Disproportionate share hospital payments.* The total annual payment adjustments made to the hospital under Section 1923 of the Act.

In addition, each State must maintain, in readily reviewable form, documentation that provides a detailed description of each DSH program, the legal basis of each DSH program, and the amount of DSH payments made to each individual public and private provider or facility each quarter.

If a State fails to comply with the reporting requirements contained in this section, future grant awards will be reduced by the amount of Federal Financial Participation (FFP) CMS estimates is attributable to the expenditures made to the disproportionate share hospitals as to which the State has not reported properly, until such time as the State complies with the reporting requirements. Deferrals and/or disallowances of equivalent amounts may also be imposed with respect to quarters for which the State has failed to report properly. Unless otherwise prohibited by law, FFP for those expenditures will be released when the State complies with all reporting requirements.

We will work with BMS to compile this information in the proper format so as to ensure it complies with the reporting requirements.

Verification Requirements

State Level Procedures

Our State level procedures will include:

- Obtaining BMS documentation including the report required in 42 CFR Section 447.299 and other information BMS would have access to, such as payments by Medicaid Managed Care Organizations and UPL payments. BMS would also be asked to obtain and provide the auditor with information on DSH payments reported by hospitals in neighboring States.
- Obtain BMS's assertion over the accuracy of the report required by Section 447.299.

- Obtaining and reviewing the State's methodology for estimating hospital-specific DSH limit and the State's DSH payment methodologies in the approved Medicaid State plan for the State plan rate year under examination.
- Obtaining and reviewing the State's DSH audit protocol to ensure consistency with Medicaid reimbursable services in the approved Medicaid State plan and to ensure that only costs eligible for DSH payments are included in the development of the hospital-specific DSH limit.
- Conducting work to assess and report on any significant internal control deficiencies of BMS's DSH program, which is a requirement under GAGAS.
- Working with BMS to notify hospitals of the examination, the expectations from the hospitals for the examination, providing them with a list of the information requirements for the examination, and the timing for when this information is to be provided. We have developed a checklist of documents required from BMS for our State Procedures and another checklist of documents to be provided by the hospitals for our Hospital Verification Procedures.
- Clarifying with BMS its responsibilities for ensuring that each provider submits its information requirements in a timely manner.
- Obtain documentation from state detailing DSH methodologies and payments.
- Compare the Provider Data Summary Schedule prepared by Clifton Gunderson to the State's DSH Reporting Schedule, noting any differences.
- Issue an independent report required under 42 CFR 455.304.

Hospital Level Procedures

The Final Rule requires six verifications at the state level and we will need to perform examination procedures at the hospital level in order to opine on those six verifications. The audit and reporting requirements apply to all states that make DSH payments and to each hospital receiving DSH payments. There are no exceptions for hospitals who receive low DSH payments. Therefore, we will conduct on-site procedures for the two largest hospitals in terms of DSH payments and desk reviews on the remaining DSH hospitals.

Why do we propose to do primarily desk reviews? First, it has been our experience that virtually all hospitals would prefer to submit documents and information to us electronically rather than have our audit staff be on-site. This minimizes disruptions to their daily operations. Our approach has been extremely effective in other states where we have performed DSH-related services. We anticipate the same success under this procurement.

Second, a field visit for purposes of the DSH audit would be limited to a review of applicable patient accounting records. Thus, the State would not receive much, if any, value from the additional cost to perform on-site reviews for a large number of hospitals . However, should the State request additional field visits, we will make the necessary revisions to our approach.

As indicated above, we will take a risk-based approach to conducting examinations at the hospital level. We will categorize the hospitals into three tiers, Level I, Level II, and Level III. The hospitals will be sorted based on DSH payments from highest to lowest. Level I will consist of the two hospitals that received the greatest amount of DSH payments. Level III will consist of those hospitals that received the lower 40% of total DSH payments. The remaining hospitals will be assigned to Level II. The 40% criteria for classifying Level I hospitals is flexible,

and can be revised prior to implementation based on the needs of BMS.

For Level I hospitals, we will perform a preliminary desk review. This desk review will consist of a "cleaning" process, and the selection of a sample from the population of total uninsured charges. Our cleaning process is discussed later in this section. Documentation to support the selected sample will be reviewed in the field. Any other items identified for follow up during the desk review will also be reviewed in the field.

For Level II hospitals, we will perform a regular desk review. This desk review will consist of a "cleaning" process, and a review of supporting documentation for a sample selected from the population of total uninsured charges.

For Level III hospitals, we will perform a limited desk review where we will only conduct the cleaning procedures on the uninsured data submitted by the hospitals. These three tiers can be further developed in subsequent consultation with BMS.

A risk-based approach to conducting an examination is appropriate under GAGAS and examination practices. Placing higher scrutiny on the hospitals receiving the largest share of DSH funds provides the auditor with the sufficient focused information necessary to express an opinion under professional standards. It also gives BMS assurance they will be in compliance with the rule while making the most efficient use of resources thereby minimizing the cost of compliance.

The specific procedures we will be performing at the hospital level include:

- Request documentation for each hospital detailing uninsured patient data and Medicaid and Medicaid-eligible patient data.
- Ensure hospital meets minimum requirements to participate in the DSH program.
- Obtain MMIS summary report and compare to provider submitted data.
- Perform detailed analysis of uninsured charges.
- Verify payments from non-governmental and non-third party payers.
- Validate data from each hospital receiving DSH payments to determine its hospital-specific DSH limit, its total annual uncompensated care cost, and amount of disproportionate share hospital payments received.
- Prepare a Provider Data Summary Schedule to compare to BMS's report required under 42 CFR Chapter IV Section 447.299.

In the first few years of this audit requirement, we anticipate a great deal of uncertainty regarding the provision of data to the auditors. In fact, our experience performing this work in other states supports this expectation. We foresee questions regarding the quantity of data, the completeness of data, and the format of the data. We will work with BMS and the hospitals on an ongoing basis to facilitate the collection of complete and auditable data.

The claims and other information to be obtained from the hospitals are likely to be in large data sets. All data requested from hospitals containing Protected Health Information ("PHI") will be transmitted through a secure File Transfer Point (FTP) site, which can accommodate extremely large data files in a secure manner. We will then use a variety of tools to work with this data, which include auditor-specific software (IDEA Data Analysis Software) and Microsoft Access. In addition, we will use a commercial application, HFS (Health Financial Systems) Medicare Cost Report software to import electronic cost report (ECR) files obtained from the State or Medicare

Fiscal Intermediary. Any proposed cost report adjustments will be applied in order to compute the routine cost center per diems and ancillary cost center cost-to-charge ratios, which are used to calculate the cost of treating uninsured and Medicaid-eligible patients at each hospital.

We realize there will be concern among hospitals, as auditees, especially in the first years of the examination, over the results. We have extensive experience in dealing with the concerns of auditees and making the examination process as transparent as possible. These efforts include providing a greater understanding of the examination process to the hospital providers, developing a protocol for communication between the auditor and auditee so giving them an avenue to voice their concerns over the examination process and/or results, and giving due process during the completion of the procedures. They will be provided every reasonable opportunity to clarify exceptions or differences identified during the examination.

We also realize many hospitals might be concerned over the burden of providing data for a new examination requirement and/or not having the data that is required under the Rule available. We understand and appreciate that not all hospitals will have all the data required for the examination for the first few years. This is occurring in our work conducted in other states. CMS has repeatedly used the phrase "best available" when referring to data to be used in the initial years of the examination requirement. Getting to a point where data is available and in the appropriate form is an iterative process and we are committed to working with the hospitals, the hospital industry, BMS and CMS in order to develop a replicable system of reporting and verification that will include all the necessary data elements to comply with the requirements of the Rule. This is the approach we have taken in other states and will be the approach we will utilize in West Virginia.

We will utilize a standard form to collect data from the hospitals, and we will provide continuous support to the hospitals to ensure timely and accurate completion of the data. Our standard form with applicable detailed instructions is already in use in our ongoing DSH audits in other states. Standardizing the submission of hospital specific data eases the burden of manipulating raw data for purposes of the DSH audit. At the same time, we understand that we must work with the hospitals in obtaining the data in the least intrusive manner possible. We give the hospitals the ability to provide their data in either a spreadsheet or database format. We have even worked with hospitals in other states in obtaining archived data in other formats.

Cleaning Methodology

The descriptions of our Project Plan to this point have made several references to cleaning uninsured data. Our cleaning process utilizes a proven application to manipulate and review the hospital charge data. We will identify and remove:

- Duplicate line items,
- Charges also billed to Medicaid,
- Dates of service outside of the Medicaid Plan year,
- Those with known insurance identifiers.

All DSH hospitals will be subjected to this process.

Sampling Methodology

For Level 1 hospitals, in addition to the cleaning process, we will select a random sample with a 90% confidence level and a 10% margin of error from the cleaned data. These parameters are the same as those used by HHS OIG in their audit work. The dollar value of unallowable charges identified from the review of patient information supporting the sampled items will be projected to the total population of charges in the following manner:

$$\frac{\text{Unallowable \$ Identified in Testing}}{\text{Total \$ in Clean Listing Sample}} \times \text{\$ in Population} = \text{Unallowable \$}$$

This projected amount will be added to the charges we had earlier disallowed through the cleaning process to arrive at the total adjustment to be made to the hospitals' reported uninsured charges.

The concept of selective testing of data and controls is generally accepted as a valid and sufficient basis for an auditor to provide assurance on the program being examined.

Why Our Approach is Best

Our approach directs time and effort to the validation of hospital uninsured charges and payments. This self-reported data has historically gone unchecked, and this fact was one of the driving forces behind the DSH audit rule. To bypass reviewing any hospital's self-reported data, or limit a review to cursory procedures is placing the State at increased risk.

Our approach to completing the DSH audit has been reviewed and approved by the former CMS official that had the primary responsibility for drafting the DSH audit rule. One of the primary reasons for the DSH audit rule is to ensure that the public interest is adequately protected. We do not perform any management functions in the administration of the West Virginia DSH program, and thus independence to perform the audit is not in question.

Training

For the initial contract year, we will conduct a training seminar to be held locally in West Virginia for the hospital personnel having the primary responsibility for providing the data to be audited. Clifton Gunderson partners and senior managers who have first hand experience with DSH will present this live training.

Having conducted similar training for hospital personnel in multiple states, we have developed a comprehensive training program that not only incorporates general DSH requirements, but addresses best practices, frequently asked questions and other customizations specific to DSH. We have included a sample agenda in *Appendix G: DSH Training.*

Work Plan Updates/Communications

Upon award of the contract, we will review the proposed work plan and procedures to see if any changes are necessary due to CMS changes, delays in the project start date, etc. We will discuss all proposed work plan changes with BMS prior to implementation.

Clifton Gunderson is committed to partnering with our clients on every engagement to ensure their needs are met and expectations are exceeded. In order to ensure our state Medicaid clients get the best value for their scarce dollars, it is necessary to maintain ongoing and open lines of communication at each step of the engagement. We are familiar with running large projects with a number of interested parties and we are comfortable communicating with multiple stake holders while ensuring that all those involved are kept informed. We know our clients do not like surprises, and neither do we. We believe our proposed communication plan will work to ensure there is an effective communication channel between Clifton Gunderson and BMS.

We propose to accomplish effective communication channels between BMS and Clifton Gunderson in the following ways:

- Monthly update conferences – status conferences on the project that would address status of work and problem areas.
- Regular on-going communications – these would be two-way *ad hoc* communications between the Engagement Partner, the Clifton Gunderson Project

Manager, and the lead managers on the engagement with Agency staff either by phone or email as soon as we encounter an issue that requires immediate Agency involvement.

BMS's project manager will be provided with the cell phone numbers of the engagement partner, senior manager, and managers so that someone from Clifton Gunderson is always available to answer questions and provide assistance.

Audit Program, Draft Report and Opinion Letter

We have provided a copy of the audit program in *Appendix H: Audit Program.* This is a preliminary draft program that will be modified prior to implementation to meet the specific needs of BMS. We have also provided a sample draft report and opinion letter as *Appendix I: Draft Report.*

Deliverables and Timeline

We have included our timeline on the following page to summarize the tasks to be performed and the anticipated completion dates for Medicaid Plan years 2005, 2006 and 2007. The timeline was developed based upon an estimated award date in May 2010 with the delivery of the final report by November 12, 2010. Our plan assumes documentation will be provided very soon after the start date. Any delay in the tasks would likely adversely affect the anticipated completion dates. Our plan anticipates no delay in receiving information from BMS. For 2005, 2006 and 2007, our plan will be to work with BMS to establish deadlines with hospitals for submission of documents to ensure that West Virginia complies with the deadline for submission of the report to CMS. In the event that CMS issues guidance or changes the timelines for submission of the engagements, we will work with BMS regarding any necessary changes in order to meet the new CMS requirements.

Staff Hours and Levels

We pride ourselves in performing high-quality, efficient audits staffed by professionals with the appropriate level of experience and expertise. Below we have outlined our proposed work hours by staff level for the 2005/2006 audits:

Staff Level	Number of Staff	Proposed Hours
Partners	1	479
Senior Manager	1	985
Managers	3	2133
Senior Associate	2	1601
Associates	4	3201

Level of Staff by Audit Program Section

Below we have outlined the engagement by audit program section and level of staffing.

Audit Program Section	Staff Level
State Procedures	
General Planning	Manager
Verification #1	Manager
Verification #2	Manager
Verification #3	Manager
Verification #4	Manager
Verification #5	Manager
Verification #6	Manager
Reporting Procedures	Manager, Sr Mgr., Partner
Hospital Procedures	
General Procedures	Associate or Sr. Associate
Scoping and Planning	Associate or Sr. Associate, Manger, Sr. Mgr., Partner
FFS Settlement Data	Associate or Sr. Associate
Medicaid MCO and Out of State Settlement Data	Associate or Sr. Associate
Uninsured Charges	Associate or Sr. Associate
Non-Gov't and Non-Third Party Pmts.	Associate or Sr. Associate
Misc Reporting Provisions	Associate or Sr. Associate
Completion of Procedures	Associate or Sr. Associate, Manager, Sr. Mgr.

West Virginia Department of Health and Human Resources
Disproportionate Share Hospital (DSH) Audits
Timeline

	TASK	Purpose of Task	July 2010	August 2010	September 2010	October 2010	November 2010	December 2010
1	Approximate Date Contract Begins		July 5, 2010					
2	Conduct Entrance Conference with BMS representatives (can be conducted via teleconference)	To explain nature of procedures, answer questions, and obtain initial information.	A date between July 5, 2010 and July 16, 2010					
3	Obtain and review DSH Allocation Schedule, MMIS data and any other DSH data from BMS	To understand nature of payments made and develop audit plan.	A date between July 5, 2010 and July 16, 2010					
4	Finalize work plan with BMS	To document the approach to the audits	A date between July 5, 2010 and July 16, 2010					
5	Provide training for hospitals	To explain what and how information needs to be provided.	No later than July 30, 2010					
6	Obtain detailed listing of uninsured, Out of State Medicaid and Medicaid MCO charges and payments and other supporting documents from hospitals	Information on which hospital-specific procedures will be performed.	All data received no later than August 31, 2010					
7	Perform hospital-specific procedures	Ensure the data used to determine DSH allocation is proper.			Completed by November 12, 2010			
8	Perform state-level procedures	Ensure DSH payments are proper.			Completed by November 12, 2010			
9	Exit Conference	Discuss results of procedures with BMS representatives and allow adequate time for response.			Completed by November 19, 2010			
10	Deliver Final Report	Summarize findings and comply with DSH Audit Rule.			On or before November 30, 2010			

NOTE: The timeline above was developed based upon an imminent start date and the assumption that providers will be cooperative in providing information. Any delay in the above tasks may defer the anticipated completion dates.

Special Terms and Conditions *(RFP Section 3.3)*

Bid and Performance Bonds (RFP Section 3.3.1)
Per the RFP, these are not required.

Insurance Requirements (RFP Section 3.3.2)
We meet or exceed all requires insurance requirements and will provide copies of our insurance certificates if chosen as the successful bidder.

License Requirements (RFP Section 3.3.3)
We have included copies of our CPA license and registration with the Secretary of State as *Appendix E: Licensing Information.*

We have maintained proper Workers' Compensation and Unemployment Insurance at or above West Virginia's requirements. Please see *Appendix E: Licensing Information* for a copy of our Workers' Compensation Certificate.

In addition, we are registered with the West Virginia Department of Administration Purchasing Division. Our Vendor Number is C26145812.

Litigation Bond (RFP Section 3.3.4)
Per the RFP, this is not required.

Debarment and Suspension (RFP Section 3.354)
Clifton Gunderson (the entity, its agency or its people) is neither debarred nor suspended.

SECTION III: QUALIFICATIONS OF PROJECT STAFF

VENDOR STAFFING

Our Proposed Engagement Team

Clifton Gunderson staffs each project to exceed our clients' expectations, including meeting all required deadlines. As we demonstrate below, our level of staffing will allow us to seamlessly transition into this contract and meet unexpected problems or delays. It has been our experience providing assurance and consulting services to Medicaid agencies that often our responsibilities are not constant, but experience peaks and valleys. Being the 14th largest CPA firm in the nation, we can draw on experienced Medicaid staff to meet that peak demand.

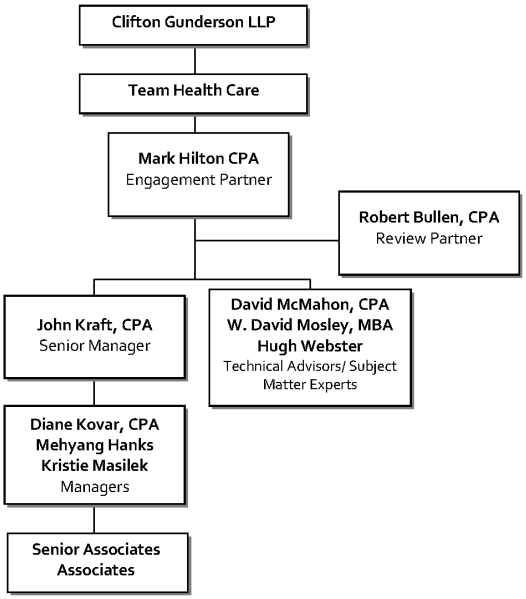
Our staff is required to obtain extensive continuing education and is given frequent internal health care specific training to keep up with the ever-changing field of health care. This institutional experience and knowledge is invaluable to BMS. We will continue to provide intensive and continuous training for our staff to ensure they understand West Virginia's Medicaid regulations and policies, as well as DSH reimbursement rules. We also cross train our staff, so someone is always available for our clients.

In addition, should the need arise, we have staff that are part of our Team Health Care practice firm-wide who work full time in the Medicaid and Medicare arena with the majority of our work being for state Medicaid programs. Medicaid professionals are located throughout the firm in our Richmond, Virginia; Baltimore, Maryland; Raleigh, North Carolina; Indianapolis, Indiana; Jackson, Mississippi; Austin, Texas, and Lansing, Michigan offices.

Furthermore, Clifton Gunderson employs highly skilled specialists with significant knowledge and experience in the health care industry. Our subject matter experts have worked for CMS or have vast senior management experience in state Medicaid agencies. These individuals offer value-added insight, provide creative solutions to our client's problems, and assist in implementing and complying with federal and state regulations. Clifton Gunderson presents every client with the benefits of this expertise.

Key Personnel

Our proposed engagement management team has a collective total of over 75 years of health care provider audit experience, including DSH experience.



We have designated an Engagement Partner who has overall responsibility for the engagement, deals with all contract issues, and guarantees top quality service. You will be supplied with all methods of contact information, so that you may contact him at anytime. In addition, we have designated a Senior Manager who will service the engagement on a day-to-day basis. The Senior Manager will also be available to BMS at all times. We believe this approach will give each requirement of the contract the high level of attention it deserves. The following descriptions highlight our senior staff members' experience and areas of expertise. In addition, we have

included their resumes in *Appendix J: Professional Resumes.*

Engagement Partner/Audit Manager

Mark K. Hilton, CPA - Partner
Mr. Hilton will have overall engagement responsibility and will serve as the manager for the common audits. He has over 26 years of audit experience relating exclusively to performing health care related services and applying Medicare and Medicaid principles of reimbursement.

Mr. Hilton serves as the engagement partner for our DSH contracts with the States of South Carolina, New Hampshire, Vermont, Oregon and the District of Columbia, as well as years of experience performing cost report audits for the State of Maryland Department of Health and Mental Hygiene. Mr. Hilton has been an active participant in the development of the protocols that have been developed for applying the DSH Audit Rule. He was the lead partner in the effort to prepare comprehensive and executive summaries of the final rule when it was published by CMS. He has had face-to-face meetings with the CMS primary author of the DSH rule as well as the CMS personnel responsible for implementing the DSH Final Rule. He has also presented specific DSH training to hospitals in South Carolina and Mississippi, various state representatives, the National Association of Human Services Finance Officers, as well as internal Clifton Gunderson personnel.

Also since 1998, Mr. Hilton has directed Clifton Gunderson's health care fraud investigation services provided to various agencies of the Department of Justice including the Criminal and Civil divisions of the United States Department of Justice Commercial Litigation Branch, the Federal Bureau of Investigation, and various Assistant United States Attorneys. These services include investigation of cost report fraud and various other false claims asserted by the government. The types of providers investigated include hospitals, home health agencies, psychiatric hospitals, rehabilitation hospitals, skilled nursing homes, and include involvement in national high profile cases investigating large hospital chains and management companies.

Mr. Hilton is a member of the Maryland Association of Certified Public Accountants, the American Institute of Certified Public Accountants, the Healthcare Financial Management Association, and the American Health Lawyers Association. In addition, he is the recipient of Clifton Gunderson's Neal E. Clifton Professionalism Award and was named by Maryland Smart CEO Magazine as one of region's Top CPAs.

Review Partner

Robert M. Bullen, CPA, CFE - Unassociated Review Partner
Mr. Bullen will assist the Engagement Partner with the day-to-day management of this contract and serve in a technical support and review capacity. He is a partner with over 25 years of experience relating exclusively to health care related audit and compliance services and applying Medicare and Medicaid principles of reimbursement.

In addition, Mr. Bullen's clients have included Commonwealth of Virginia Department of Medical Assistance Services, State of Maryland Department of Health and Mental Hygiene HealthChoice Program, CMS Office of the Actuary, CMS Division of Capitated Plan Audits, North Carolina Division of Medical Assistance, State of Maryland Health Care Commission and CMS Office of Research, Development and Information.

Mr. Bullen is a Certified Public Accountant and a Certified Fraud Examiner. He is member of the Maryland Association of Certified Public Accountants, the American Institute of Certified Public Accountants, the Association of Certified

Fraud Examiners, and the American Health Lawyers Association.

Senior Manager

John Kraft, CPA, CHFP - Senior Manager
Mr. Kraft will serve as the Senior Manager of this contract. He will work with the Partner to schedule audits, train and assign staff, respond to questions (from BMS, providers, and staff), and perform the first level management workpaper and report review.

For the past 20 years, he has performed Medicare and Medicaid audit, desk review and rate calculation services. He also serves as the senior manager of our DSH contract with the States of South Carolina, New Hampshire, Vermont, Oregon and the District of Columbia, In addition, he has provided litigation support for our Medicaid clients' cost report appeals. He also has performed various cost report audit services for Carefirst of Maryland, the former Medicare fiscal intermediary. Most recently, he has been a key participant in the health care litigation support practice area.

Mr. Kraft is a member of the Maryland Association of Certified Public Accountants, the American Institute of Certified Public Accountants, the Healthcare Financial Management Association, and the American Health Lawyers Association.

Technical Advisors

David McMahon, CPA - Senior Manager - Subject Matter Expert
Mr. McMahon will be available to assist BMS as a technical advisor and subject matter expert. He has assisted multiple state agencies with hospital and DSH reimbursement issues in his role as senior manager. Throughout his 14 years of experience, he has performed audit and consulting work for the state agencies of Mississippi, North Carolina, Alabama, Nevada, and Texas. Also unique, Mr. McMahon has a wealth of experience pertaining to hospital reporting and operations, as he was previously employed by one of the nation's larger hospitals, where his responsibilities included generating the Medicare cost report each year.

Mr. McMahon is a recognized expert in the area of Medicare and Medicaid hospital reimbursement. He has presented at numerous external and internal health care conferences. Furthermore, he presented Cost Report Audit Training for CMS Medicare Part A staff.

W. David Mosley, MBA - Principal/Director, Office of Government Services-Subject Matter Expert
Mr. Mosley will be available to assist BMS as a subject matter expert on the technical requirements of the DSH rule and also as a liaison with CMS as necessary. He has more than 12 years of demonstrated success in negotiating with government agencies to increase funding, abate penalties and implement innovative practices. Mr. Mosley has worked extensively in the health and human services field, specifically for the State of North Carolina Division of Medical Assistance, the Department of Health and Human Services, and the Governor's Business Committee for Education.

Mr. Mosley's primary focus is on government health care and he maintains exceptional relationships with elected officials, regulators, and leaders across the Nation. He provides clients with valuable insight, policy consulting, and technical assistance while empowering them to realize success. Further, he is regularly called upon to offer input at the highest level of government, including recent service to senior members of the U.S. Senate.

Mr. Mosley maintains excellent relationships with the U.S. Department of Health and Human Services (HHS), OIG, CMS and Congressional leadership and has an in-depth understanding of and a unique ability to communicate with

stakeholders on complex Medicaid funding issues including, but not limited to: rate setting, DSH programs, Upper Payment Limit (UPL) strategies, pharmacy best practices, audit programs, assessment initiatives, regulatory compliance, institutional reimbursement, rate setting, audit, managed care, waiver efforts, and Medicaid management information systems (MMIS), and data analysis. Further, he regularly represents the interests of Medicaid clients in effective communication (including testimony, negotiations, and presentations) with elected officials, regulators, and leaders at all levels of government.

Mr. Mosley served as Assistant Director for North Carolina's $9 billion Medicaid program, with a monthly average of 1.2 million Medicaid beneficiaries. For the past five years, he has worked with clients across the nation in order to address complex financing, reimbursement, auditing, and policy issues relating to government health care.

Hugh Webster, Senior Manager - Subject Matter Expert

Mr. Webster will be available to assist BMS as a subject matter expert on the technical requirements of the DSH rule and also as a liaison with CMS as necessary. The former CMS Atlanta Region Branch Manager of Financial and Programmatic Operations of Medicaid and State Children's Health Insurance Program (SCHIP), Mr. Webster possesses over 31 years of audit, management, analysis and consulting experience in the health care industry and government sector. He has extensive knowledge of a broad spectrum of complex Medicaid issues in various states that are critical to the ongoing success of state operations.

Previously responsible for the oversight of long-term care expenditures in eight of the largest Medicaid programs in the nation, Mr. Webster focused on complex hospital reimbursement programs and the state plans, audits, and regulations affecting them. He is highly qualified in areas related to Medicaid and SCHIP agency performance, State Medicaid/ SCHIP quarterly budget and expenditure reports, complex funding mechanisms (CPE, IGT, taxes, and donations), and the DSH program. In his professional capacity, Mr. Webster was charged with not only understanding the myriad of complexities associated with institutional reimbursement, but also possessing the ability to articulate these complexities in a manner that was understood by all stakeholders, including CMS leadership, state officials, provider associations, and the Office of Inspector General. Further, Mr. Webster maintains excellent personal and professional relationships with federal regulators and state leaders across the nation.

Managers

Diane Kovar, CPA- Manager

Ms. Kovar will work directly with the Senior Manager in completing the audits of the data provided by the hospitals and the state. Ms. Kovar has over ten years of experience with Clifton Gunderson working on health care-related audits, fraud investigations, and litigation support services. Her clients have included the South Carolina Department of Health and Human Services DSH Audits, the Maryland Department of Health and Mental Hygiene, and CMS. Ms. Kovar is a Certified Public Accountant.

Mehyang Hanks, Manager

Ms. Hanks will work directly with the Senior Manager in completing the audits of the data provided by the hospitals and the state. A new addition to Clifton Gunderson, she has over 10 years of experience in the health care industry including supervising audits of hospital and health-care facilities. With highly developed industry knowledge, she served as a first line resource for workflow and technical related processes, questions, reviews, technical guidance and direction. In addition, she held leadership roles in overseeing and review all work performed by the staff to ensure compliance with GAAP and Government Auditing Standards.

Kristie Masilek, Manager
Ms. Masilek will work directly with the Senior Manager in completing the audits of the data provided by the hospitals and the state. She has more than 11 years of experience working on health care-related audits including the South Carolina Department of Health and Human Services DSH Audits, Maryland Department of Health and Mental Hygiene, and CMS.

Additional Staff Resources
We will assign senior associates and associates from our Baltimore, Maryland and Richmond, Virginia offices as needed. We assure BMS that the quality of staff will be maintained over the term of the contract agreement due to the depth of our experience with Medicaid agencies.

Staffing Chart
On the following page, we have included a Staffing Chart for this engagement.

Specialists
As evidenced throughout *Section III,* all of our proposed staff are highly skilled in DSH audits, as well as health care auditing in general. We will not require the services of any outside specialists.

Subcontractors
We have the expertise, experience and resources to complete the engagement without the use of subcontractors.

West Virginia DSH Audits Overview of Staff

Name	Title and Years of Medicare/ Medicaid Audit Experience	Federal and State Experience *(*DSH Experience)*	Professional Organizations	Role in Engagement	Percent of Total Time Devoted to Project *(Key Staff Only)*	Percent of Total Project Hours *(Key Staff Only)*
Mark K. Hilton , CPA	Partner – 26 years	States: South Carolina*, District of Columbia*, New Hampshire*, Vermont*, Oregon*, Maryland Federal: FBI, CMS	American Institute of CPAs (AICPA), Maryland Association of CPAs (MACPA), American Health Lawyers Association	Engagement Partner/ Overall engagement responsibility for project coordination and management of common audit	Yr. 1 – 14% Yr. 2 – 5% Yr.3 – 5%	Yr. 1 – 6% Yr. 2 – 6% Yr.3 – 6%
Robert M. Bullen, CPA, CFE	Partner – 25 years	States: Maryland, North Carolina, Kansas, Virginia, Federal: CMS	AICPA, MACPA, American Health Lawyers Association, Association of Certified Fraud Examiners	Unassociated Review	--	----
John Kraft, CPA, CHFP	Senior Manager - 21 years	States: South Carolina*, Maryland, Virginia, District of Columbia*, New Hampshire*, Vermont*, Oregon* Federal: OIG, CMS, FBI	***AICPA, MACPA, Healthcare Financial Management Association American Health Lawyers Association***	***Senior Manager Scheduling of audits, training and assign staff, respond to questions, perform first level management workpaper and report***	Yr. 1 – 29% Yr. 2 – 9% Yr.3 – 9%	Yr. 1 –12% Yr. 2 – 12% Yr.3 – 12%
William David Mosley, MBA	Principal/ Director, Office of Government Services - 12 years	States: North Carolina, Alabama*, Mississippi*, South Carolina*, Kansas, Texas, Tennessee	***American Hospital Association, American Management, Financial Management Association***	Subject Matter Expert	--	----
David McMahon, CPA	Senior Manager - 14 years	States: Mississippi*, North Carolina, South Carolina*, Alabama*, Texas, Nevada	***AICPA, South Carolina Association of Certified Public Accountants***	Subject Matter Expert	--	----
Hugh Webster	Senior Health Care Manager - 31 years	Federal: CMS*	***National Association of State Medicaid Directors, National Association of Human Service Finance Directors***	Subject Matter Expert	--	----
Diane Kovar, CPA	Manager - 10 years	States: South Carolina*, Maryland Federal: FBI, CMS	***AICPA, Maryland Association of CPAs***	***Manager Work directly with the Senior Manager in completing the audits of the data provided by the hospitals and the state***	Yr. 1 –21% Yr. 2 – 7% Yr.3 – 6%	Yr. 1 –8% Yr. 2 – 8% Yr.3 – 8%
Mehyang Hanks	Manager - 10years	States: South Carolina*, New Hampshire*, District of Columbia*, Georgia Federal: FBI	--	***Manager Work directly with the Senior Manager in completing the audits of the data provided by the hospitals and the state***	Yr. 1 – 21% Yr. 2 – 7% Yr.3 –6%	Yr. 1 –8% Yr. 2 – 8% Yr.3 – 8%
Kristie Masilek	Manager - 11 years	States: South Carolina*, Maryland Federal: FBI, CMS	--	Manager Work directly with the Senior Manager in completing the audits of the data provided by the hospitals and the state	Yr. 1 – 21% Yr. 2 – 7% Yr.3 – 6%	Yr. 1 –8% Yr. 2 – 8% Yr.3 – 8%

Staff Training

Clifton Gunderson is dedicated to ensuring only the highest-quality staffing arrangements for each of its clients. Your Clifton Gunderson engagement team has both the technical background specific to the engagement requirements and the practical business experience required to understand and contribute to your decision-making process.

Our firm requires all partners and staff to annually participate in a minimum of 40 hours of continuing professional education courses. This includes a minimum of 24 hours every two years directly related to governmental auditing in accordance with the standards set forth in the Yellow Book. Through our internal and external continuing professional education, we ensure that our professionals meet the requirements established by the AICPA and contained in the Generally Accepted Governmental Audit Standards (GAGAS).

In addition, we require our health care audit staff to receive specific formal training in the areas of health care auditing and reimbursement issues. Our formal training is coupled with on-the-job experience and communication with our clients in helping them solve their problems. A benefit derived by our clients from this process is receiving regular updates of current audit and accounting issues and their potential impact on clients.

Specifically, each of our health care staff members participate in internal "GROW" training. This consists of the following four levels:

- **G**roundwork (For associate level staff): This program covers basic accounting and auditing updates and reviews including independence, assurance services, and specialization. It includes such health care topics as Overview and Structure of Government Health Care Reimbursement Systems, Government Health Care Terms, and Medicare Cost Reports for SNFs, HHAs, Hospitals, and Home Offices.

- **R**esults (For senior associate level staff): This program covers advanced accounting and auditing updates and reviews such as audit planning and analytical procedures. It includes such health care topics as Dealing with Adversarial Communication and An Overview of State Reimbursement Policies.

- **O**pportunities (For senior associate staff): This program also covers advanced accounting and auditing updates and reviews including audit efficiency techniques and information technology. It includes such health care topics as Medicare Update, Medicaid Update, and An Overview of Health Care Fraud.

- **W**isdom (For manager level staff): This program is geared toward individuals in supervisory roles and covers such issues as leadership, motivation, effective communication, and high-performance teams.

In addition to the GROW program, Clifton Gunderson sustains the staff's knowledge through our THRIVE program. As part of THRIVE, health care staff attends an annual Team Health Care Conference. This conference is designed to provide an in-depth update to the participants on current health care related issues, so they can continue to provide quality client service. The topics and speakers are geared toward the services we provide to federal and state government health care agencies. Past topics covered include statistical sampling, Medicaid and Medicare updates, fraud, and HIPAA.

In addition, the members of your team routinely attend relevant national health care conferences to stay current with trends and issues. These conferences have included:

- National Association for Medicaid Program Integrity: Annual Conference
- National Health Care Anti-Fraud Association: Annual Training Conference
- Association of State Human Services Finance Officers (HSFO): Annual Conference
- Health Care Compliance Association: Annual Meeting
- American Health Lawyers Association: Institute on Medicare and Medicaid Payment Issues
- American Health Lawyers Association: Long Term Care and the Law
- National Association of Medicaid Directors: Annual Conference
- National Managed Health Care Congress Conference

Staffing Capacity

With more than 150 members on our Team Health Care Staff and more than 500 on our firm-wide Public Sector Team, we feel that we have the capacity to staff this engagement without hiring additional staff. As mentioned previously, we know that our clients will not be successful unless we provide them with the highest quality, responsive, and experienced Medicaid consulting staff. We, as a firm and individually, pride ourselves on the depth of experience of our professionals and we will provide that same level of expertise to the State of West Virginia. All staff members dedicated to this contract have direct, hands-on experience performing auditing and consulting services for state Medicaid agencies. These are full time health care compliance professionals, not personnel who do state agency work only in the "slow time" of the year when they are not working on other clients. Furthermore, our supervisory staff committed to this engagement possesses direct DSH audit experience, which will enable us to commence the engagement on day one with unparalleled client service. Medicaid staff are located throughout the firm in our Richmond, Virginia; Baltimore, Maryland; Raleigh, North Carolina; Austin, Texas; Indianapolis, Indiana; Jackson, Mississippi; and Lansing, Michigan offices.

SECTION IV: DOCUMENTATION

SPECIAL TERMS AND CONDITIONS

We have no special terms or conditions to disclose.

SIGNED FORMS

The following forms have been included in *Appendix K: Required Form.*:

- MED-96
- Purchasing Affidavit
- Addendum Acknowledgement

In addition, if chosen as the successful bidder, we are prepared to comply with the HIPAA Business Associate Addendum (BAA).

CHECKLIST

We have completed Attachment I: RFP Requirements' Checklist and have included in *Tab: Table of Contents/Checklist.*.

SECTION V: COST

COST SUMMARY

We have included our cost proposal in a separately sealed envelope.

APPENDIX A:
CERTIFICATE OF AUTHORITY

Clifton Gunderson LLP
Certified Public Accountants & Consultants

May 12, 2010

Mr. Bryan Rosen
Office of Purchasing
West Virginia Department of Health and Human Resources
One Davis Square, Suite #100
Charleston, WV 25301

Dear Mr. Rosen:

Authorizing Document

I am the Chief Executive Officer of Clifton Gunderson LLP. Clifton Gunderson is a Limited Liability Partnership with its Administrative Office located in Milwaukee, Wisconsin. Mark Hilton is a Partner in Clifton Gunderson LLP, and accordingly can contractually bind the firm. Mr. Hilton is authorized to bind Clifton Gunderson LLP on all matters dealing with the State of West Virginia.

If you require any further information, please contact me at 414-476-1880.

Very truly yours,

CLIFTON GUNDERSON LLP

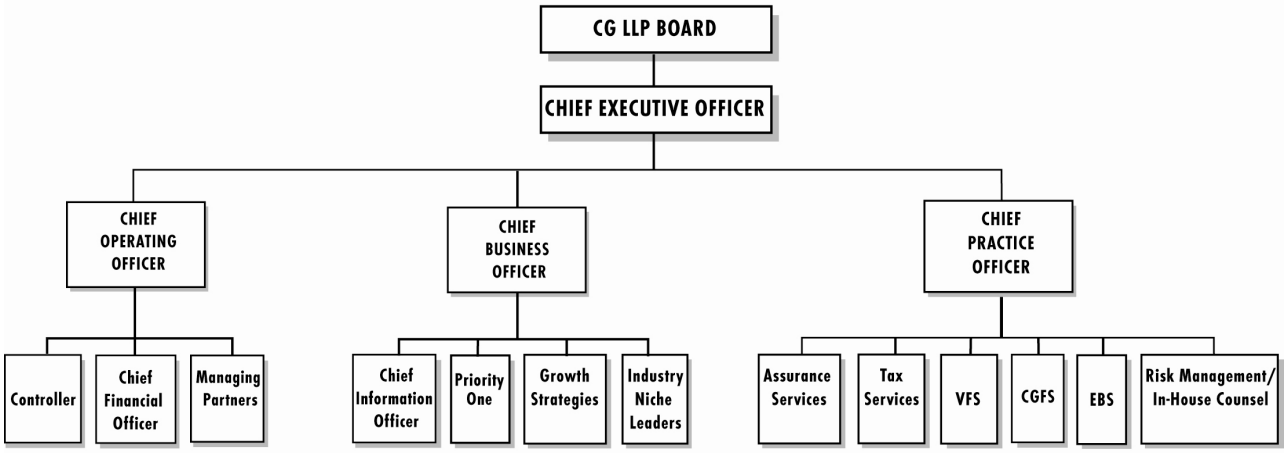
Krista M. McMasters

Krista M. McMasters
Chief Executive Officer

10001 Innovation Drive
Milwaukee, WI 53226
Tel: 414.476.1880
Fax: 414.476.7286
www.cliftoncpa.com

APPENDIX B:
ORGANIZATIONAL CHART

FIRM ORGANIZATIONAL CHART



CLIENT SERVICE CENTERS

ROCKY MOUNTAIN CSC
Albuquerque, NM
Broomfield, CO
Greenwood Village, CO
Lenexa, KS

HEARTLAND CSC
Cedar Rapids, IA
Des Moines, IA

GREATER CHICAGOLAND CSC
Joliet, IL
Oak Brook, IL
Schererville, IN

INDIANAPOLIS CSC
Indianapolis, IN
Jackson, MS

DOWNSTATE IL CSC
Champaign
Danville
Dixon
Peoria
Princeton
Sterling

MID-ATLANTIC CSC
Arlington, VA
Baltimore,MD
Mechanicsburg, PA
Philadelphia, PA
Raleigh, NC
Richmond, VA
Washington, DC

SOUTHWEST CSC
Phoenix, AZ
Rancho Cucamonga, CA
Tucson, AZ
Austin, TX

ONE WISCONSIN CSC
Madison
Marshfield
Milwaukee
Oshkosh
Racine
Sheboygan
Sparta
Stevens Point
Tomah

ST. JOSEPH CSC

TOLEDO CSC

VFS CSC

REVISED 3/29/10

APPENDIX C:
PEER REVIEW

LE MASTER & DANIELS PLLC

SPOKANE
COLFAX
GRANDVIEW
MOSES LAKE
OMAK
OTHELLO
QUINCY
TRI-CITIES
WALLA WALLA
WENATCHEE
YAKIMA
BOISE

ACCOUNTING
AND
CONSULTING
SERVICES

MEMBER OF
McGLADREY
NETWORK

To the Partners of
Clifton Gunderson LLP
and the Center for Public Company Audit Firms Peer Review Committee

We have reviewed the system of quality control for the accounting and auditing practice of Clifton Gunderson LLP (the firm) applicable to non-SEC issuers in effect for the year ended July 31, 2007. The firm's accounting and auditing practice applicable to SEC issuers was not reviewed by us since the Public Company Accounting Oversight Board (PCAOB) is responsible for inspecting that portion of the firm's accounting and auditing practice in accordance with PCAOB requirements. A system of quality control encompasses the firm's organizational structure and the policies adopted and procedures established to provide it with reasonable assurance of complying with professional standards. The elements of quality control are described in the Statements on Quality Control Standards issued by the American Institute of Certified Public Accountants (the AICPA). The design of the system, and compliance with it, are the responsibilities of the firm. Our responsibility is to express an opinion on the design of the system, and the firm's compliance with that system based on our review.

Our review was conducted in accordance with standards established by the Peer Review Committee of the Center for Public Company Audit Firms and included procedures to plan and perform the review that are summarized in the attached description of the peer review process. Our review would not necessarily disclose all weaknesses in the system of quality control or all instances of lack of compliance with it since it was based on selective tests. Because there are inherent limitations in the effectiveness of any system of quality control, departures from the system may occur and not be detected. Also, projection of any evaluation of a system of quality control to future periods is subject to the risk that the system of quality control may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

In our opinion, the system of quality control for the accounting and auditing practice applicable to the non-SEC issuers of Clifton Gunderson LLP in effect for the year ended July 31, 2007, has been designed to meet the requirements of the quality control standards for an accounting and auditing practice established by the AICPA, and was complied with during the year then ended to provide the firm with reasonable assurance of complying with applicable professional standards.

LeMaster & Daniels PLLC

Spokane, Washington
December 19, 2007

APPENDIX D:
PROFESSIONAL PROFILES

State of South Carolina

Department of Health and Human Services
Disproportionate Share Hospital Program Agreed-Upon Procedures Services

Project Requirements	As the prime contractor, perform agreed-upon procedures of the Disproportionate Share Hospital (DSH) program. Procedures performed satisfy the requirements in the CMS proposed rule to implement section 1001(d) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) which establishes new reporting and auditing requirements for State Disproportionate Share Hospital payments.
Technical Approach Taken	South Carolina currently has 70 hospitals that qualify for Medicaid DSH payments. Clifton Gunderson validates DSH Survey data on a hospital-specific basis in order to assess the State's compliance with applicable federal and state regulations. Three levels of testing are performed: • Hospital Desk Procedures • Hospital On-Site Procedures • State Procedures
Periods of Performance	January 4, 2006 - December 31, 2010 (initial contract) January 1, 2011 – December 31, 2015 (contract extension)
Deliverables	• Draft Agreed-Upon Procedures Report • Final Agreed-Upon Procedures Report
Reference	Mr. William L. Wells, CPA, Deputy Director Finance and Administration South Carolina Department of Health and Human Services 1801 Main Street, Room 633 Columbia, South Carolina 29201 803-898-1058 wells@dhhs.state.sc.us Ms. Patty H. Larimore, Director of Procurement South Carolina Department of Health and Human Services 1801 Main Street, Room 633 Columbia, South Carolina 29201 803-898-2667 larimph@scdhhs.gov

State of Mississippi

Office of the Governor
Division of Medicaid
Medicaid Accounting and Reimbursement Consulting Services

Project Requirements

As prime contractor, provide the State with Medicaid program reimbursement policy and operational consulting services including, but not limited to: expert legislative testimony, facilitating communication with senior CMS staff, detailed analysis of OIG findings, and recommendations regarding audit initiatives.

Examination of Medicaid providers in order to assess the appropriateness of costs claimed in association with providing Medicaid services.

For the Mississippi Division of Medicaid we have been engaged to perform the 2005, 2006, 2007 and 2008 DSH audits. In addition, we have been engaged to perform an analysis of the state's DSH program in accordance with the Final DSH Audit Rule as promulgated by CMS on December 19, 2008. We performed a review of DSH calculations, policies, and procedures as performed by the Mississippi Hospital Association on behalf of the Division of Medicaid. That engagement also included a review of DSH policies and procedures performed at the State level. In addition, we continue to assist the State in developing a comprehensive plan to maximize DSH and UPL reimbursement. That project also includes an extensive ongoing examination of hospital specific uninsured charges and payments for compliance with current and proposed regulations.

Technical Approach Taken

Review of nursing facility cost reports submitted to the Division of Medicaid to establish per diem rates for reimbursement. Steps include:

- Conduct pre-engagement planning meetings prior to fieldwork.
- Data analysis to highlight areas where the Medicaid cost report appears to be outside of expected norms.
- Inspection of physical facility for indications of improper cost reporting and/or substandard care.
- Review of resident census to ensure proper reporting.
- Vouching of expenses (on a sample basis) reported on the Medicaid cost report for validity, reasonableness, proper classification, and allowability.
- Examination of home office expenses, including the home office allocations and expense detail for proper allocation methodology and expense validity.
- Review of statistics used to allocate costs (as applicable).
- Review resident billings for discounting.
- Recalculate per diem rates and outpatient reimbursement percentages.

Review of hospital Medicare cost reports submitted to the Division of Medicaid to establish per diem rates for reimbursement. Steps include:

- Conduct pre-engagement planning meetings prior to fieldwork.
- Data analysis to highlight areas where the Medicare cost report appears to be outside of expected norms.
- Inspection of physical facility for indications of improper cost reporting and/or substandard care.
- Review of resident census to ensure proper reporting.
- Vouching of expenses (on a sample basis) reported on the Medicare cost report for validity, reasonableness, proper classification, and allowability.
- Examination of home office expenses, including the home office allocations and expense detail for proper allocation methodology and expense validity.
- Review of statistics used to allocate costs.
- Recalculate per diem rates and outpatient reimbursement percentages.
- Review uninsured cost data submitted by hospitals to the Division of Medicaid to support their Disproportionate Share Hospital (DSH) allotment. Steps include:
- Verify the Medicare Cost-to-Charge Ratio.
- Select a statistically valid sample of uninsured charges and payments.
- Review documentation to validate uninsured charges. The documentation consists of collection notes, claim detail, charity care applications, billing records, etc.
- Review documentation, including accounts receivable detail, to validate uninsured payments.

Review claims submitted to the Division of Medicaid by therapy providers, mental health facilities, and hospitals for reimbursement. Steps include:

- Conduct pre-engagement planning meetings prior to fieldwork.
- Data analysis to highlight areas where reimbursement appears to be outside of expected norms.
- Data analysis for duplicate billings.
- Select statistical valid sample of claims.
- Inspection of physical facility to gain understanding of the services provided.
- Review documentation to validate submitted claims. This documentation consists of, but are not limited to, medical records, physician orders, treatment plans, eligibility verifications, physician notes, test results (laboratory tests, x-ray, EKG, etc.), and therapy notes.

Evaluated performance of the Program Integrity bureau within the Division of Medicaid. Steps included:

- Interview key personnel.
- Examine processes used to identify possible cases of fraud and abuse.
- Examine audit techniques to maximize return to DOM.
- Assess the relationship between the Program Integrity department and the Medicaid Fraud Control Unit.
- Assess compliance with federal and state regulations.

Risk assessment of the State Children's Health Insurance Payments (SCHIP) Program. Steps included:

- Interview key personnel.
- Review contractual requirements between the Division of Medicaid, the Department of Finance Administration, and the contractor of the SCHIP program.
- Assess compliance with federal and state regulations.

Evaluated the performance of the contractor responsible for maintaining the Medicaid Management Information System (MMIS). Steps included:

- Interview key personnel.
- Review contractual requirements between the Division of Medicaid and the contractor of the MMIS system.
- Assess compliance with federal and state regulations.

Review of Medicaid and uninsured data submitted by a large regional trauma center (located in Memphis, Tennessee) to the State of Mississippi for DSH and UPL reimbursement. Steps included:

- Review of submitted Medicaid and uninsured claims for reasonableness and allowability under Mississippi State Plan guidelines
- Verification of cost-to-charge ratio from the Medicare cost report used in the calculation for DSH reimbursement

Review of the Medicaid's Supplemental Drug Rebate Program to verify the payments received by drug companies were appropriate.

Assisted the Division of Medicaid in preparing the State's response to the proposed rule (now final but under moratorium) issued by CMS regarding Intergovernmental Transfers (IGTs), Certified Public Expenditures (CPEs), and limiting government providers to cost. Expert witness testimony was also provided to the Mississippi Legislature Medicaid Committee regarding this rule.

Periods of Performance

- Initial contract: July 2006 - June 2008 (with 2 one-year renewal options)
- First Contract Extension: July 1, 2007 – June 30, 2008
- Second Contract Extension: July 1, 2008 – June 30, 2009

Deliverables

- Draft Consulting Report
- Final Consulting Report
- Detailed analysis and modeling of provider costs and profitability
- Oral presentations to legislature, senior staff, and providers

Reference

Lynda Dutton, Deputy Administrator
Walter Sillers Building
550 High Street, Suite 1000
Jackson, Mississippi 39201
601-359-6108
Lynda.Dutton@medicaid.ms.gov

State of Alabama

Alabama Medicaid Agency
Medicaid Accounting and Consulting Services

Project Requirements

Clifton Gunderson conducts reviews of the Certificate Public Expenditures (CPE) claimed by the State of Alabama to fund the state share used to draw down federal funds for Medicaid and Disproportionate Share Hospital (DSH) payments to public hospitals.

Technical Approach Taken

Calculate CPE settlement for the State Fiscal Year 2006 and future years using protocol required by CMS. Steps taken:

- Obtain cost reports from Medicare fiscal intermediary for public hospitals.
- Obtain uninsured charges and payments from public hospitals.
- Obtain Medicaid charge data for the Medicaid Management Information System (MMIS) and other State providers.
- Clean uninsured data using methodology approved by CMS to determine allowable uninsured charges and payments for DSH.
- Complete CMS protocol worksheets to determine Medicaid and DSH costs compare to federal funds claimed by the State and determine the interim and final settlements.

Periods of Performance

May 2008 – May 2010

Deliverables

- Interim Settlement Report
- Final Settlement Report
- Oral presentations to hospital representatives regarding the CPE settlement process
- Consulting work on rate structures for hospital payments

Reference

Ms. Carol H. Steckel, MPH, Commissioner
Alabama Medicaid Agency
501 Dexter Avenue
P.O, Box 5624
Montgomery, Alabama 36103-5624
334-242-5600
Carol.Steckel@medicaid.alabama.gov

State of Vermont

Vermont Agency of Human Services
Disproportionate Share Hospital Audits

Project Requirements

Conduct an independent examination of the State of Vermont's compliance with the federal government DSH regulations for payments made in Federal fiscal years 2005, 2006, 2007, and 2008. The examination is to be performed to determine whether individual hospitals qualified for DSH payments based upon the criteria set forth in the Social Security Act and that the payments to individual hospitals did not exceed the limits imposed by the Omnibus Budget Reconciliation Act (OBRA) of 1993.

Technical Approach Taken

- 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.
- Review State's DSH audit protocol to ensure consistency with In-patient/Out-patient (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.
- Compile hospital specific IP/OP cost report data and IP/OP revenue data to measure hospital specific DSH limit in auditable year. Compile total DSH payments made in auditable year to each qualifying hospital (including DSH payments received by the hospitals from other States).
- 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.

Periods of Performance

April 15, 2010 – June 15, 2010

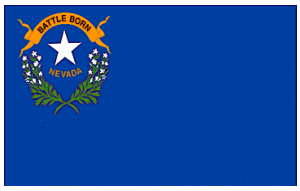
Deliverables

Examination report that complies with the requirements of the December 19, 2008 Medicaid Disproportionate Share Hospital (DSH) final rule (73FR 77904) specific requirements §455.304 (d).

Reference

Ursula Boehringer, AHS Audit Chief
Internal Audit Group
State of Vermont
103 South Main Street Osgood 1
Waterbury, Vermont 05671-3710
802-241-1047
Ursula.Boehringer@ahs.state.vt.us

State of Nevada



Department of Health and Human Services
Disproportionate Share Hospital Consulting Services.

Project Requirements

Clifton Gunderson performed compliance audits of 15 Nevada Hospitals pursuant to NRS 439B.440 for the periods from July 1, 2005 through June 30, 2007 and from July 1, 2007 through June 30, 2009. Amended in November 2007 to include a Risk Assessment Audit of the State's Disproportionate Share Hospital payment process and the Risk Assessment Audit of eight hospital Uncompensated Care Cost Reports.

Technical Approach Taken

Compliance Audits

- Review hospital's policies and procedures regarding the 30 percent discount to uninsured patients and ensure they are consistent with NRS 439B.260. Test sample of inpatient bills to ensure the hospital advised uninsured patients of their right to receive a discount and that patients who made reasonable arrangements were given the discount.
- Review hospital's emergency room policies and procedures to ensure they are consistent with NRS 439B.410 requiring hospitals to provide emergency care and services regardless of the patient's financial status. Review the emergency room patient log and test a sample of patients who were transferred from or to the hospital's emergency room to determine that the transfer was appropriate pursuant to NRS 439B.410.
- Review hospital's contractual arrangements with physicians or other medical care providers to ensure they are in compliance with NRS 439B.420. Test a sample of contracts to ensure the terms, including compensation and rent are in compliance with NRS 439B.420.
- Review hospital's contractual arrangements with related entities to ensure they are in compliance with NRS 439B.430. Reconcile the related party balance sheet and expense accounts to the activities by year.

Risk Assessment Audits

- Analyze the state's rules, policies & procedures and State Plan related to the disproportionate share hospital (DSH) payment program. Assess compliance with federal laws and CMS rules and regulations, both current and prospective.
- Review the DSH and private hospital Upper Payment Limit (UPL) program

operational practices in order to develop program process maps. Assess compliance with established policies and procedures. Identify areas of non-compliance, inefficiency and ineffectiveness (in any) proposing recommendations to address non-compliance and increase efficiency and effectiveness.

- Analyze reported hospital data assessing risk that the underlying hospital data is unreliable. Propose recommendations to address risks identified through follow-up audits.
- Review data supporting Uncompensated Care Cost Reports (UCCR) at selected hospitals for completeness, accuracy and compliance with reporting instructions. Test a sample of inpatient and outpatient bills to ensure charges and payments have been properly classified as uninsured or Medicaid.
- Reconcile data reported on the UCCR to the data reported by each selected hospital to Medicare and to the state's health information database.

Periods of Performance

First Contract: January 1, 2004 – June 30, 2006
Second Contract: July 1, 2007 – June 30, 2010

Deliverables

Report on agreed upon procedures for each hospital and each period examined.

Reference

Ms. Janice Prentice
State of Nevada
Division of Health Care Financing and Policy
1100 E. William Street, Suite 119
Carson City, Nevada 89701
775-684-3791
jprentice@dhcfp.nv.gov

State of Michigan

Department of Community Health
Disproportionate Share Hospital Audits

Project Requirements

Conducted a review of Michigan's DSH program to verify the DSH payments were in compliance with the Michigan State Plan and federal laws and regulations. The review was performed to determine whether individual hospitals qualified for DSH payments based upon the criteria set forth in the Social Security Act and the payments to individual hospitals did not exceed the limits imposed by the Omnibus Budget Reconciliation Act (OBRA) of 1993.

Technical Approach Taken

- Reviews of submitted Medicaid and uninsured claims for reasonableness and allowability under Michigan State Plan guidelines.
- Verification of cost-to-charge ratios from the Medicare cost report used in the calculation for DSH reimbursement
- Verification of the DSH reimbursement methodology for compliance wit the State Plan and Federal laws and regulations
- Compared the amount of uninsured costs claimed to the amount of DSH payment received by each hospital

Periods of Performance

October 2009 - present

Deliverables

- Draft of Agreed-Upon Procedures Report
- Final of Agreed-Upon Procedures Report

Reference

Mr. Brian Keisling, Manager
State of Michigan
Department of Community Health
Medical Services Administration
400 S. Pine Street, 7th Floor
Lansing, MI 48913
517-241-7181
keislingb@michigan.gov

State of North Dakota

Department of Human Services
Disproportionate Share Hospital Program Consulting Services

Project Requirements

Clifton Gunderson conducted a review of North Dakota's DSH program to verify the DSH payments were in compliance with the North Dakota State Plan and federal laws and regulations. The review was performed to determine whether individual hospitals qualified for DSH payments based upon the criteria set forth in the Social Security Act and the payments to individual hospitals did not exceed the limits imposed by the Omnibus Budget Reconciliation Act (OBRA) of 1993.

Technical Approach Taken

- Interviewed key personnel.
- Reviewed the process of calculating the State's DSH payments for individual hospitals.
- Verified the DSH reimbursement methodology was in compliance with the North Dakota State Plan and federal laws and regulations.
- Obtained uninsured charges and payments from hospitals.
- Calculated the hospital specific Medicaid shortfall or profit.
- Obtained uninsured charges and payments from hospitals.
- Compared the amount of uninsured costs claimed to the amount of DSH payments received by each hospital.
- Performed the Upper Payment Limit calculation.

Periods of Performance

March 2008 – April 2009

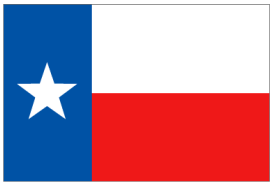
Deliverables

- Draft Agreed-Upon Procedures Report
- Final Agreed-Upon Procedures Report

Reference

Ms. Maggie Anderson, Director
North Dakota Department of Human Services
Division of Medical Services
600 E. Boulevard Avenue, Suite 325
Bismarck, North Dakota 58505
701-328-1603
manderson@nd.gov

State of Texas



Health and Human Services Commission (HHSC)

Disproportionate Share Hospital Audits

DSH Risk Assessment

Project Requirements

Clifton Gunderson was engaged to conduct DSH audits under examination standards for 2005, 2006, and 2007. This includes the audit of approximately 180 hospitals per year; conducting DSH training for hospitals; and performing agreed upon procedures for the state on UPL payments to five private hospitals on their compliance with the private hospital UPL program.

In addition, we have also performed a risk assessment of the State's DSH program. We also conducted an agreed upon procedures engagement to review the reliability of reported uninsured charges reported by five large urban hospitals participating in the DSH program.

As part of our risk assessment of the DSH program, we performed an analysis of the Department's current rules, policies and procedures, including the State Plan under Title XIX of the Social Security Act, an assessment of the risk of non-compliance with current and proposed DSH rules promulgated by CMS; an assessment of the risk that the State's current DSH program operational practices do not ensure compliance with established policies and procedures; and an analysis and assessment of the risk that the underlying hospital cost data submitted to the Department may not be reliable. We also provided HHSC with proposed responses to mitigate the risks that we had identified. For the agreed-upon procedures engagement at the selected hospitals, through interviews, observations, and manual and computerized analysis of data, we reviewed each selected hospital's policy and procedures for uninsured care days, indigent care, and charity charges to ascertain compliance with DSH conditions of participation; determine whether the hospital claims for uninsured care were accurately reported in accordance with criteria mutually agreed to with HHSC and based on the Code of Federal Regulations (CFR) and the Texas Administrative Code (TAC); projected inaccuracies identified in our statistically valid samples over the entire populations of claims; and provided HHSC with a written report of the outcome of the accuracy of the hospital claims for uninsured data.

Technical Approach Taken

DSH Audits:

- Reviews of submitted Medicaid and uninsured claims for reasonableness and allowability under State Plan guidelines.
- Verification of the DSH reimbursement methodology for compliance with the State Plan and Federal laws and regulations
- Compare the amount of uninsured costs claimed to the amount of DSH payment received by each hospital

Risk Assessment:
In identifying the areas of risks, Clifton Gunderson reviewed:

- The related Request for Proposal published by HHSC
- The proposal submitted by each individual MCO
- The contract between HHSC and each MCO
- Subcontracts between each MCO and other service contractors
- Monthly reports on MCO operations and performance that were submitted to HHSC
- Other supporting information HHSC staff or MCO staff felt would be useful in gaining a general understanding of the MCOs' operations and delivery of services

We built a list of potential risk areas for each MCO based upon contract requirements and information provided by, and interviews with the MCO staff and HHSC staff.

Periods of Performance

HHSC Overall Contract

- Initial Contract: August 2005 – December 2005
- First Contract Extension: January 2006 – December 2006
- Second Contract Extension: January 2007 – December 2007
- Third Contract Extension: January 2008 – December 2008
- Fourth Contract Extension: January 2009 – August 3, 2009

DSH Audits: February 2010-November 2010

Deliverables

- Examination report for DSH
- AUP report for UPL
- Four training sessions for hospital representatives on the DSH audit
- Risk assessment/accuracy reports

Reference

Mr. Kevin Nolting
Director of Hospital Reimbursement
TX Health and Human Services Commission
11209 Metric Blvd., Building H
Austin, TX 78758
512-491-1348
kevin.nolting@hhsc.state.tx.us

Mr. Max Mrasek
Procurement Project Manager, Contract Administration
Texas Health and Human Services Commission
11209 Metric Boulevard
Austin, Texas 78758
512-491-1316
max.mrasek@hhsc.state.tx.us

Commonwealth of Virginia

Department of Medical Assistance Services
Cost Settlements/Field Verifications of Medicaid Providers

Project Requirements

Clifton Gunderson completed field verifications for the following provider types: nursing homes, nursing homes with Specialized Care, rehabilitation agencies, Intermediate Care Facilities for the Mentally Retarded, Federally Qualified Health Clinics, rural health clinics, and home offices to ensure compliance with Medicaid and Medicare regulations, principles, and policies. We are currently performing DSH audit procedures on all Virginia DSH hospitals for 2005 and 2006.

Technical Approach Taken

- Conduct field verification pre-field planning procedures. This includes reviewing the field verification request form and gaining an understanding of the issues, performing analytical procedures and identifying expenses for further review, meeting with staff who performed cost settlement to clarify settlement findings, meeting with appeals personnel to understand any appeal issues, conducting an engagement planning meeting between the senior manager and/or manager and all staff assigned to the verification to discuss the issues, review a Clifton Gunderson designed tool to determine a provider's relationship to the ceilings and develop materiality levels, and formulate the verification plan. Pre-field planning also includes obtaining "up-front" documentation such as the general Ledger to promote efficiency.
- Perform on-site verification utilizing the DMAS verification program to determine whether the statistical information is accurate; whether the submitted expenses are reasonable, necessary, related to patient care, allowable, adequately documented, and properly classified; and whether any income should be offset against expenses. Address issues that are all or in part unique to Virginia, such as refinancing, new construction, and sale of assets. Hold exit conference on the last day of fieldwork to discuss all proposed adjustments and Management Report comments with provider representatives.
- Perform post-field procedures including accepting and evaluating additional provider information submitted within regulatory time frames, making revisions to adjustments as necessary, and keeping the provider informed of all changes.
- Finalize adjustment reports noting questioned costs and regulatory citations.
- Staff auditors perform field verifications. A Senior Manager or a Manager performs a detailed review. A Senior Manager performs a final review and the engagement partner performs a pre-issuance review.
- Constantly evaluate and update field verification processes to ensure efficiency and effectiveness and that designed procedures are relevant to the current environment.

- Provide support for the Medicaid Fraud Control Unit on an as needed basis.
- Keep DMAS representatives informed of progress and consult with them on any unusual and/or major issues.
- Performed audits of the multi-settlement cost reports for the Virginia state teaching hospitals. The multi-settlement cost report is used to determine the cost of uncompensated care provided to Medicaid HMO patients, indigent patients as defined by the State, uninsured patients based on the Federal definition, and physician's costs of providing care to these groups of patients.

Periods of Performance

- First Contract: July 1, 1993 - December 31, 1994
- Second Contract: January 1, 1995 - December 31, 1995
- Third Contract: January 1, 1996 - December 31, 1996
- Fourth Contract: January 1, 1997 - December 31, 1999
- Fifth Contract: January 1, 2000 - December 31, 2005
- Sixth Contract: January 1, 2006 - December 31, 2008 (with three annual renewal options)
- First Contract Extension: January 1, 2009 – December 31, 2009

Deliverables

- Report on agreed upon procedures
- Notice of Amount of Program Reimbursement
- Settlement Summary
- Adjustment Reports
- Revised Cost Reports
- Management Letter
- Monthly Progress Reports

Reference

Mr. James Branham, Manager, Provider Reimbursement Division
Department of Medical Assistance Services
Commonwealth of Virginia
600 East Broad Street, Richmond, Virginia 23219
804-225-4587
james.branham@dmas.virginia.gov

Mr. William Lessard, Director, Provider Reimbursement Division
Department of Medical Assistance Services
Commonwealth of Virginia
600 East Broad Street, Richmond, Virginia 23219
804-225-4593
william.lessard@dmas.virginia.gov

State of Oklahoma

Oklahoma Health Care Division
Disproportionate Share Hospital Audits

Project Requirements	Clifton Gunderson has been retained by the State of Oklahoma to perform the DSH audits for state plan rate years 2005, 2006, and 2007. For the Oklahoma Health Care Division, we have been engaged to perform the 2005, 2006, and 2007 DSH audits. In addition, we have been engaged to perform an analysis of the State's DSH program in accordance with the final DSH rule as promulgated by CMS on December 19, 2008. We performed a review of DSH calculations, policies and procedures as performed by the Oklahoma Health Care Division. That engagement also included a review of DSH polices and procedures performed at the State level.
Technical Approach Taken	• Reviews of submitted Medicaid and uninsured claims for reasonableness and allowability under Oklahoma State Plan guidelines. • Verification of cost-to-charge ratios from the Medicare cost report used in the calculation for DSH reimbursement • Verification of the DSH reimbursement methodology for compliance wit the State Plan and Federal laws and regulations • Compared the amount of uninsured costs claimed to the amount of DSH payment received by each hospital
Periods of Performance	May 2009-December 2010
Deliverables	Draft of Agreed-Upon Procedures Report Final Agreed-Upon Procedures Report
Reference	Mr. Stephen Weiss, Sr. Policy Advisor Oklahoma Health Care Authority 4545 North Lincoln Boulevard Oklahoma City, Oklahoma 73105-3413 405-522-7530 Stephen.weiss@okhca.org

State of Washington

Department of Social and Health Services
Disproportionate Share Hospital Audits

Project Requirements

Clifton Gunderson has been awarded a contract by the State of Washington to perform the DSH audits for state plan rate years 2005 and 2006.

For the Department of Social and Health Services, we have been engaged to perform the 2005 and 2006 DSH audits. As part of this engagement, w will perform a review of DSH calculations, policies and procedures as performed by the Department of Social and Health Services. The engagement also included a review of DSH polices and procedures performed at the State level.

Technical Approach Taken

- Reviews of submitted Medicaid and uninsured claims for reasonableness and allowability under Washington State Plan guidelines.
- Verification of the DSH reimbursement methodology for compliance with the State Plan and Federal laws and regulations
- Compare the amount of uninsured costs claimed to the amount of DSH payment received by each hospital

Periods of Performance

May 2009-December 2010

Deliverables

- Draft of Examination Report
- Final Examination Procedures Report

Reference

Sandy Stith, Chief
Office of Financial Operations
Division of Rates and Finance
Health & Recovery Services Administration
360-725-1949

State of Arkansas

Arkansas Department of Human Services
Disproportionate Share Hospital Audits

Project Requirements

Conducted a review of Arkansas's DSH program to verify the DSH payments were in compliance with the Arkansas State Plan and federal laws and regulations. The review was performed to determine whether individual hospitals qualified for DSH payments based upon the criteria set forth in the Social Security Act and the payments to individual hospitals did not exceed the limits imposed by the Omnibus Budget Reconciliation Act (OBRA) of 1993.

Technical Approach Taken

- Reviews of submitted Medicaid and uninsured claims for reasonableness and allowability under Arkansas State Plan guidelines.
- Verification of cost-to-charge ratios from the Medicare cost report used in the calculation for DSH reimbursement
- Verification of the DSH reimbursement methodology for compliance with the State Plan and Federal laws and regulations

  Compared the amount of uninsured costs claimed to the amount of DSH payment received by each hospital

Periods of Performance

November 2009 - present

Deliverables

- Draft of Agreed-Upon Procedures Report

  Final of Agreed-Upon Procedures Report

Reference

Mr. Tom Show, Manager
State of Arkansas
Department of Human Services
Division of Medical Services
P.O. Box 1437 Slot S401
Little Rock, Arkansas 72203
501-682-2483
Tom.Show@arkansas.gov

State of New Hampshire

New Hampshire Department of Health and Human Services
Disproportionate Share Hospital Audits

Project Requirements	Clifton Gunderson has been awarded a contract by the State of New Hampshire to perform the DSH audits for state plan rate years 2005 through 2008. For the Department of Health and Human Services Office of Medicaid Business and Policy, we have been engaged to perform the 2005 through 2008 DSH audits. As part of this engagement, we will perform a review of DSH calculations, policies and procedures as performed by the Office of Medicaid Business and Policy. The engagement also includes a review of DSH polices and procedures performed at the State level.
Technical Approach Taken	• Reviews of submitted Medicaid and uninsured claims for reasonableness and allowability under New Hampshire State Plan and Federal guidelines. • Verification of the DSH reimbursement methodology for compliance wit the State Plan and Federal laws and regulations • Compare the amount of uninsured and Medicaid costs claimed less revenues to the amount of DSH payment received by each hospital
Periods of Performance	September 2009 to December 2011
Deliverables	• Draft of Examination Report • Final Examination Procedures Report
Reference	Mr. Paul Casey Business Administrator Department of Health and Human Services 603-271-4382

State of Oregon

Oregon Department of Human Services
Disproportionate Share Hospital Audits

Project Requirements	Clifton Gunderson has been awarded a contract by the State of Oregon to perform the DSH audits for state plan rate years 2005 through 2008, with optional extension years through 2010. For the Division of Medical Assistance Programs, we have been engaged to perform the 2005 through 2008 DSH audits. As part of this engagement, we will perform a review of DSH calculations, policies and procedures as performed by the Division of Medical Assistance Programs. The engagement also includes a review of DSH polices and procedures performed at the State level.
Technical Approach Taken	• Reviews of submitted Medicaid and uninsured claims for reasonableness and allowability under Oregon State Plan guidelines. • Verification of the DSH reimbursement methodology for compliance wit the State Plan and Federal laws and regulations • Compare the amount of uninsured costs claimed to the amount of DSH payment received by each hospital
Periods of Performance	November 2009-October 2013
Deliverables	• Draft of Examination Report • Final Examination Procedures Report
Reference	Angel Wynia, Contract Administrator Division of Medical Assistance Programs 503-945-5754

APPENDIX E:
LICENSING INFORMATION

State of West Virginia
West Virginia Board of Accountancy
106 Capitol Street, Suite 100
Charleston, WV 25301
(304) 558-3557

The entity listed below was issued a
FIRM PERMIT
for the period beginning
July 1, 2009 through June 30, 2010

F0347A
CLIFTON GUNDERSON LLP
301 SW ADAMS ST STE 600
PEORIA IL 61602

Reed Spangler
Reed Spangler, CPA, Board President
Jo Ann Walker, Executive Director

West Virginia Board of Accountancy
106 Capitol Street, Suite 100
Charleston, WV 25301
(304) 558-3557

Your fee has been received for renewal of your firm permit. This registration may be detached from the perforation at left and used until the date indicated.

Any errors in the attached information should be reported to the Board office at 304/558-3557

Reed Spangler
Reed Spangler, CPA, Board President
Jo Ann Walker, Executive Director

State of West Virginia
West Virginia Board of Accountancy
106 Capitol Street, Suite 100
Charleston, WV 25301
(304) 558-3557

The entity listed below was issued an
Authorization to Perform
Attest and/or Compilation Services
for the period beginning
July 1, 2009 through June 30, 2010

F0347A
CLIFTON GUNDERSON LLP
301 SW ADAMS ST STE 600
PEORIA IL 61602

Reed Spangler
Reed Spangler, CPA, Board President
Jo Ann Walker, Executive Director

West Virginia Board of Accountancy
106 Capitol Street, Suite 100
Charleston, WV 25301
(304) 558-3557

Your fee has been received for your firm's Authorization to Perform Attest or Compilation Services in West Virginia. This Authorization may be detached and used until the date indicated.

Any errors in the attached information should be reported to the Board office at 304/558-3557

Reed Spangler
Reed Spangler, CPA, Board President
Jo Ann Walker, Executive Director

West Virginia Secretary of State
Business Organization Information System

Home On-Line Reference

Name:	CLIFTON GUNDERSON LLP						
Type:	LLP	Eff Date:	6/12/2006	Ch Type:	F	Term Date:	6/10/2010
Sec Type:		Fil Date:	6/10/2008	Class:	P	Term Reas:	X

Main | Addresses | Officers | DBAs | Names | Mergers | Subsidiaries
Amendments | Ann Reports | Dissolutions | Results | New Search | Logoff

Main

Ch County:	0	Bus Purp:				AW/Term:	Par Val:
		Ch State:	DE	Ex Acres:		Term Yrs:	Auth Shrs:
				Ctrl Num:	85938	Mgmt:	Cap Stck:

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 07/13/2009

PRODUCER		THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW.	
	877-945-7378 Willis of Wisconsin, Inc. 26 Century Blvd. P. O. Box 305191 Nashville, TN 37230-5191	INSURERS AFFORDING COVERAGE	NAIC#
INSURED	Clifton Gunderson LLP ATTN: Tiffany Ulbing 10001 Innovation Drive Suite 201 Milwaukee, WI 53226	INSURER A: Hartford Underwriters Insurance Co.	30104-000
		INSURER B:	
		INSURER C:	
		INSURER D:	
		INSURER E:	

COVERAGES

THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. AGGREGATE LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	ADD'L INSRD	TYPE OF INSURANCE	POLICY NUMBER	POLICY EFFECTIVE DATE (MM/DD/YYYY)	POLICY EXPIRATION DATE (MM/DD/YYYY)	LIMITS	
		GENERAL LIABILITY				EACH OCCURRENCE	$
		COMMERCIAL GENERAL LIABILITY				DAMAGE TO RENTED PREMISES (Ea occurence)	$
		CLAIMS MADE OCCUR				MED EXP (Any one person)	$
						PERSONAL & ADV INJURY	$
						GENERAL AGGREGATE	$
		GEN'L AGGREGATE LIMIT APPLIES PER:				PRODUCTS - COMP/OP AGG	$
		POLICY PRO-JECT LOC					
		AUTOMOBILE LIABILITY				COMBINED SINGLE LIMIT (Ea accident)	$
		ANY AUTO					
		ALL OWNED AUTOS				BODILY INJURY (Per person)	$
		SCHEDULED AUTOS					
		HIRED AUTOS				BODILY INJURY (Per accident)	$
		NON-OWNED AUTOS					
						PROPERTY DAMAGE (Per accident)	$
		GARAGE LIABILITY				AUTO ONLY - EA ACCIDENT	$
		ANY AUTO				OTHER THAN AUTO ONLY: EA ACC	$
						AGG	$
		EXCESS / UMBRELLA LIABILITY				EACH OCCURRENCE	$
		OCCUR CLAIMS MADE				AGGREGATE	$
							$
		DEDUCTIBLE					$
		RETENTION $					$
A		**WORKERS COMPENSATION AND EMPLOYERS' LIABILITY** Y/N	83WBIJ9131	6/1/2009	6/1/2010	X WC STATU-TORY LIMITS OTH-ER	
		ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? N **(Mandatory in NH)** If yes, describe under SPECIAL PROVISIONS below				E.L. EACH ACCIDENT	$ 1,000,000
						E.L. DISEASE - EA EMPLOYEE	$ 1,000,000
						E.L. DISEASE - POLICY LIMIT	$ 1,000,000
		OTHER					

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES / EXCLUSIONS ADDED BY ENDORSEMENT / SPECIAL PROVISIONS

CERTIFICATE HOLDER	CANCELLATION
For Information Purposes ONLY	SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, THE ISSUING INSURER WILL ENDEAVOR TO MAIL 45 DAYS WRITTEN NOTICE TO THE CERTIFICATE HOLDER NAMED TO THE LEFT, BUT FAILURE TO DO SO SHALL IMPOSE NO OBLIGATION OR LIABILITY OF ANY KIND UPON THE INSURER, ITS AGENTS OR REPRESENTATIVES. AUTHORIZED REPRESENTATIVE James H. Graber

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IMPORTANT

If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

DISCLAIMER

This Certificate of Insurance does not constitute a contract between the issuing insurer(s), authorized representative or producer, and the certificate holder, nor does it affirmatively or negatively amend, extend or alter the coverage afforded by the policies listed thereon.

APPENDIX F:
FRIZZERA EMAIL

FRIZZERA REVIEW OF PROCEDURES
VIA EMAIL – MAY 7, 2009

From: Jim Frizzera [mailto:jfrizzera@healthmanagement.com]
Sent: Thursday, May 07, 2009 9:44 AM
To: Mosley, Dave
Cc: Hilton, Mark
Subject:

Dear Dave:

It was a pleasure to meet with you, Mark Hilton, John Kraft, Frank Vito, and Selvadas Govind on Monday, May 4, 2009, at the Clifton Gunderson office in Baltimore, Maryland. I found our meeting to be very informative and productive. I appreciated everyone's willingness to engage in great detail and to take into consideration the feedback I provided during our meeting.

The Medicaid disproportionate share hospital (DSH) reporting and audit requirements enacted under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), and the final rule implementing such requirements impose specific documentation and verification processes on the part of both State Medicaid programs and DSH hospitals. Clearly, the five years that you and your Firm have spent developing concise programs, methods, and data requirements will be of benefit to State Medicaid programs and to the Federal government as they review the results of the audits you perform.

I reviewed the following documentation that you and your team have developed to satisfy the DSH audit requirements as articulated in the implementing regulation issued by the Centers for Medicare and Medicaid Services (CMS) on December 19, 2008, and in the associated DSH Audit and Reporting Protocol:

- request for data required from hospitals
- request for data required from States
- training materials for hospitals (PowerPoint presentation)
- audit procedures for hospital supplied data
- audit procedures for State supplied data and State processes

During our meeting we discussed the correlation of data requirements, processes, and procedures to the specific requirements defined by CMS in the final regulation and the associated protocol. Based on the documentation provided during our meeting and the detailed discussion related to that material, it is apparent that you and your Firm have a clear understanding of the specific

Congressional and Federal regulatory basis and instruction of the requirements imposed on the Medicaid DSH program. It is my opinion that the data elements you have identified, the validation processes you have developed, and the training materials you created satisfy all Medicaid DSH audit requirements in a clear, concise manner. Your Firm's approach to addressing the Medicaid DSH audit requirements should provide the Federal government, State governments, and hospitals with a new level of transparency and insight into the effective management of comprehensive hospital reimbursement efforts.

I look forward to working with you and others at Clifton Gunderson to further address this matter and others affecting the critical needs of our Nations health care infrastructure.

Sincerely

Jim Frizzera, Principal

Health Management Associates

APPENDIX G:
DSH Training

State
Medicaid Disproportionate Share Program
DSH Audit and Reporting Rule Conference
Date

Program Agenda

9:00-9:10	Opening Remarks
9:10-9:30	Overview of Federal DSH Audit and Reporting Rule
9:30-10:00	Documentation Needed from Hospitals
10:00-10:15	**Break**
10:15-10:45	Overview of Process to Review Uninsured Charges
10:45-11:15	Use of Cost Reports in the Process
11:15-11:30	Documentation Submission Deadlines
11:30-12:00	Question and Answer Session

APPENDIX H:
SAMPLE AUDIT PROGRAM

This proposal includes data that shall not be disclosed outside the Government and shall not be duplicated, used, or disclosed - in whole or in part - for any purpose other than to evaluate this proposal. All data marked CONFIDENTIAL herein are subject to this restriction.

Below is the rationale for those items marked as confidential:

- *Sample Audit Program:* We are privately owned and consider specifics of our audit programs to be confidential and proprietary; therefore, our programs contained in *Appendix H: Sample Audit Program* are marked "Confidential."

- *Sample Draft Report:* We are privately owned and consider specifics of our reporting and reporting mechanisms to be confidential and proprietary; therefore, our reports contained in *Appendix I: Sample Draft Report* is marked "Confidential."

If you have any questions regarding the above, please contact Mark Hilton at 410-453-0900 or Mark.Hilton@cliftoncpa.com.

Disproportionate Share Hospital Payment Audit
Examination Procedures - State

State: West Virginia

MSP Rate Year: 6/30/

Summary of Exhibits

Exhibit	Exhibit Description	Initials	Date Completed
A.	General Planning Procedures		
B.	Verification #1 Procedures to determine if each hospital that qualifies for a DSH payment in the State is allowed to retain that payment.		
C.	Verification #2 Procedures to determine that DSH payments made to each qualifying hospital comply with the hospital-specific DSH payment limit.		
D.	Verification #3 Procedures to determine if only uncompensated care costs of furnishing inpatient and outpatient hospital services are included the calculation of the hospital-specific limit.		
E.	Verification #4 Procedures to determine if Medicaid payments in excess of the Medicaid costs are applied against the uncompensated care costs.		
F.	Verification #5 Procedures to determine if the State has adequate documentation for payments.		
G.	Verification #6 Procedures to determine and document how the State defines incurred inpatient hospital and outpatient hospital costs.		
H.	CG Reporting Procedures		

Confidential - Not for Distribution

Summary of Exhibits

Disproportionate Share Hospital Payment Audit
Examination Procedures - State

State: West Virginia

MSP Rate Year: 6/30/

Exhibit A – General Planning Procedures

Purpose: To document general planning and administrative procedures for conducting verifications required under the DSH audit rule as specified in 42 CFR 455.304(d)(1).

	AUP Step	Staff Initials	W/P Ref	Comments
1.	Complete State documentation checklist at **A-2** and for any items not obtained send letter or email to State requesting documentation.			
2.	Through inquiry and review of State's DSH procedures and policies, determine State's DSH Plan Year. The State's DSH Plan Year is defined as 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.			
3.	Maintain throughout the engagement a "Notes to Subsequent Auditors" for use in following cost reporting periods. A copy of this point sheet should be included at **W/P 14**.			
4.	Obtain State's estimate of hospital specific DSH limit that was determined when the DSH payments for the Medicaid State Plan (MSP) rate year were calculated.			
5.	Accumulate Provider Data Summary Schedule (PDSS) and note any differences from State's DSH			

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Disproportionate Share Hospital Payment Audit
Examination Procedures - State

State West Virginia

MSP Rate Year 6/30/

	AUP Step	Staff Initials	W/P Ref	Comments
	Reporting Schedule (DRS).			

Confidential - Not for Distribution

Exhibit A

Disproportionate Share Hospital Payment Audit
Examination Procedures - State

State: West Virginia

MSP Rate Year: 6/30/

Exhibit B – Verification One

Purpose: To conduct steps to report on Verification One of the DSH Audit Rule that 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 ***as specified in 42 CFR 455.304(d)(1).***

	AUP Step	Staff Initials	W/P Ref	Comments
1.	Verify from state documentation that each hospital has met the federal DSH criteria or the State defined DSH qualification criteria for the MSP rate year under review.			
2.	Identify the different mechanisms used by the State to fund DSH. Follow the procedures identified below to verify that the state is not reducing providers' DSH payments by the amount of any IGT, provider tax, or other funding mechanism, and that the DSH payment equals the CPE.			
3.	If the State uses Certified Public Expenditures (CPE), verify that the DSH payment agrees to CPE filed by the State for claiming of Federal funds.			
4.	If the State uses Intergovernmental Transfers (IGT) perform the following: a. Verify that the state has not required providers to IGT DSH funds back to the state after disbursement. b. Verify that the State receives an IGT from the providers. c. Verify that the provider received			

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Disproportionate Share Hospital Payment Audit
Examination Procedures - State

State: West Virginia

MSP Rate Year: 6/30/

	AUP Step	Staff Initials	W/P Ref	Comments
	the full DSH payment in a separate transaction. Note-If this work was done at the hospital level, summarize work performed and any findings.			
5.	If state funds (or other tax receipts) finance the DSH program, verify that the entire state and federal components are retained by the provider and that the State has not required the providers to return any portion of the DSH payment.			
6.	Verify with State if any redistribution or recovery has been made made based on identification of DSH payments made in excess of hospital specific limits. If so, obtain documentation from the State that the redistribution or recovery was made based on the results of the hospital verification procedures.			
7.	Verify that state has updated DRS to include DSH Payments made by Out of State Medicaid State Agencies.			
8.	Generate verification assessment language for Verification One based on results of procedures.			

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Disproportionate Share Hospital Payment Audit
Examination Procedures - State

State: West Virginia

MSP Rate Year: 6/30/

Exhibit C – Verification Two

Purpose: To ensure DSH payments made to each qualifying hospital comply with the hospital-specific DSH payment limit as specified in 42 CFR 455.304(d)(2).

	AUP Step	Staff Initials	W/P Ref	Comments
1.	Prepare summary schedule detailing the State's procedures performed to determine whether or not the State made DSH payments that exceeded any provider's specific DSH limit during the Medicaid State plan rate year.			
2.	Utilizing the individual Provider Data Summary Schedules, summarize the hospital-specific uncompensated care costs incurred during the Medicaid State plan year under examination. Compare hospital-specific DSH payments to the uncompensated care costs and note any providers where the DSH payments exceeded the hospital-specific uncompensated care costs.			
3.	Prepare verification assessment language for Verification #2 to note whether the State's procedures satisfy the Federal regulation at Section 1923(g)(1)(A) of the Act and that identify any providers that exceeded their hospital-specific DSH payment limit.			

Confidential - Not for Distribution

Disproportionate Share Hospital Payment Audit
Examination Procedures - State

State: West Virginia

MSP Rate Year: 6/30/

Exhibit D – Verification Three

Purpose: To ensure that 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 as specified in 42 CFR 455.304(d)(3).

	AUP Step	Staff Initials	W/P Ref	Comments
1.	Prepare summary schedule detailing the State's procedures performed to determine that only the uncompensated care costs of providing inpatient and outpatient hospital services to Medicaid eligible individuals and uninsured individuals are included in the calculation of the hospital-specific limits.			
2	Assess whether the state's procedures only use uncompensated care costs of i/p and o/p hospital services in calculation of hospital specific limits.			
3.	Prepare verification assessment language for Verification #3 to note whether the State's procedures satisfy the Federal regulation at Section 1923(g)(1)(A) of the Act.			

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Disproportionate Share Hospital Payment Audit
Examination Procedures - State

State West Virginia

MSP Rate Year 6/30/

Exhibit E – Verification Four

Purpose: To ensure that all Medicaid payments, including supplemental/enhanced Medicaid payments, are in the calculation of the hospital-specific DSH limit as specified in 42 CFR 455.304(d)(4).

	AUP Step	Staff Initials	W/P Ref	Comments
1.	Prepare summary schedule detailing the State's procedures performed to determine that all payments (Medicaid FFS, Medicaid managed care, and supplemental/enhanced Medicaid payments) have been included in the calculation of the hospital-specific DHS limits.			
2.	a. Assess whether the state's procedures take into account all payments (Medicaid FFS, Medicaid managed care, and supplemental/enhanced Medicaid payments) in the calculation of hospital specific limits.			
3.	Prepare verification assessment language for Verification #4 to note whether the State's procedures satisfy the Federal regulation at Section 1923 of the Act.			

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Disproportionate Share Hospital Payment Audit
Examination Procedures - State

State: West Virginia

MSP Rate Year: 6/30/

Exhibit F – Verification Five

Purpose: To ensure that the State has separately documented and retained a record of all its costs under the Medicaid program, uninsured costs in the 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 Act as specified in 42 CFR 455.304(d)(5).

	AUP Step	Staff Initials	W/P Ref	Comments
1.	Obtain copies of the State's policies and procedures regarding documentation retention related to information and records of all inpatient and outpatient hospital service costs under the Medicaid program; claimed expenditures under the Medicaid program; uninsured inpatient and outpatient hospital service costs in determining payment adjustments; and, any payments made on behalf of the uninsured from payment adjustments under Section 1923 of the Act.			
2.	Prepare summary schedule detailing the State's documentation procedures including the specific data elements retained by the State.			
3	Assess whether the state has documented and retained information and records of all of its inpatient and outpatient hospital service costs under the Medicaid program; claimed expenditures under the Medicaid program; uninsured inpatient and outpatient hospital service costs in determining payment adjustments under this Section; and any payments made on behalf of the uninsured from payment adjustments under this Section has been separately documented and retained by the State.			

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Disproportionate Share Hospital Payment Audit
Examination Procedures - State

State West Virginia

MSP Rate Year 6/30/

	AUP Step	Staff Initials	W/P Ref	Comments
4.	Prepare verification assessment language for Verification #5 to note whether the State's procedures satisfy the Federal regulation at Section 1923 of the Act.			

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Disproportionate Share Hospital Payment Audit
Examination Procedures - State

State West Virginia

MSP Rate Year 6/30/

Exhibit G – Verification Six

Purpose: To ensure that the information specified in Verification #6 includes a description of the methodology for calculating each hospital's payment limit under Section 1923(g)(1) of the Act, including how the State defines incurred inpatient hospital and outpatient hospital costs for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individual and individuals with no source of third party coverage for the inpatient and outpatient services they receive as specified in 42 CFR 455.304(d)(6).

	AUP Step	Staff Initials	W/P Ref	Comments
1.	Obtain documentation from the State outlining the methodology used to calculate the hospital-specific DSH limit and methodology used to calculate the various DSH payments. Review for compliance with applicable regulations.			
2.	Review state's DSH procedures to ensure consistency with IP/OP Medicaid reimbursable services in the approved Medicaid State Plan.			
3.	Review DSH procedures to ensure that only costs eligible for DSH payments are included in the development of the hospital specific DSH limit.			
4.	Review State Plan section covering DSH payments and prepare summary of State's payment methodology.			
5	Assess and document how the State defines incurred inpatient hospital and outpatient hospital costs for furnishing inpatient hospital and outpatient hospital services to Medicaid eligible individuals and individuals with no source of third party coverage for the inpatient hospital and outpatient hospital services they received.			
5.	Prepare verification assessment language for Verification Six to note whether the State's procedures satisfy the Federal regulation at			

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Disproportionate Share Hospital Payment Audit
Examination Procedures - State

State: West Virginia

MSP Rate Year: 6/30/

	AUP Step	Staff Initials	W/P Ref	Comments
	Section 1923 of the Act.			

Confidential - Not for Distribution

Disproportionate Share Hospital Payment Audit
Examination Procedures - State

State West Virginia

MSP Rate Year 6/30/

Exhibit H – CG Reporting Procedures

Purpose: CG Internal Control Program for reporting phase of DSH payment audits

Audit Step	Staff Initials	W/P Ref	Comments
1. Ensure the Provider Data Summary Schedule (PDSS) is populated based on procedures done at the state and with each provider and that sections reviewed are cross-referenced to the appropriate workpapers.			
2. Obtain a representation letter from the state.			
3. Submit report and workpapers for senior manager or partner review as appropriate.			
4. Prepare draft report and send copy to State. Make arrangements for exit conference.			
5. Conduct exit conference with State personnel.			
6. Make any final revisions to the report.			
7. Complete examination review and unassociated partner review.			
8. Issue independent examination report required under 42 CFR §455.204.			

CG Manger/Senior Associate Review Completed _____ Initials _____ Date

CG Senior Manager Review Completed: _____ Initials _____ Date

Confidential - Not for Distribution

West Virginia Department of Health and Human Resources
Disproportionate Share Hospital Program
Examination Procedures
MSP Rate Year _____

Provider Name _____

Provider Number _____

Fiscal Years Under Review _____

	Name	Date
CG Manager/Senior Associate Review Completed		
	Initials	Date
CG Senior manager Review Completed		
	Initials	Date

Confidential - Not for Distribution

West Virginia Department of Health and Human Resources
Disproportionate Share Hospital Program
Examination Procedures
MSP Rate Year _____

Provider Name _____

Provider Number _____

Fiscal Year Under Review _____

Summary of Exhibits

Exhibit	Exhibit Description	Initials	Date Completed
A	General Procedures		
B	Scoping and Planning Procedures		
C	Reserved		
D	FFS Settlement		
E	Managed Care and Out Of State Settlement		
F	Uninsured Charges		
G	Non-Governmental and Non-Third Party Payer Payments		
H	Miscellaneous Hospital Reporting Provisions		
I	Completion of Procedures/Final Hospital Reporting		

Confidential -
Not for Distribution

West Virginia Department of Health and Human Resources
Disproportionate Share Hospital Program
Examination Procedures
MSP Rate Year _____

Provider Name _____

Provider Number _____

Fiscal Years Under Review _____

Exhibit A – General Procedures

Purpose: To determine the acceptability of the information filed by the provider and the extent of the review to be performed on the information.

	AUP Step	Staff Initials	W/P Ref	Comments
1.	Complete hospital documentation checklist at **A-2** and for any items not obtained send letter or email to providers requesting documentation. When requesting information from providers, bear in mind that if their cost reporting period does not correspond with the Medicaid State plan rate year under audit, the hospitals must use two or more Medicare cost reports to provide information requested. This needs to be communicated to the hospital as part of the documentation request.			
2.	Set-up secure FTP website for each provider to submit all documentation. Documentation during onsite visit (if applicable) should be submitted via secure FTP website. Web address is: http://secure.cliftoncpa.com.			
3.	Review all pertinent provider files, such as prior years' workpapers, correspondence files, permanent files, etc. Make note of any items which will require special attention and cross-reference to the appropriate workpapers.			

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	AUP Step	Staff Initials	W/P Ref	Comments
4.	Determine if Medicare has issued a Notice of Provider Reimbursement (NPR) for cost report(s) during the MSP rate year. Obtain copy of the NPR package.			
5.	Perform the conversion of the finalized ECR file if received from the Medicare fiscal intermediary or the as-filed ECR if the cost report has not been finalized into the HFS software. The following steps must be completed: a. Ensure there are no variances between the cost report and the ECR file (i.e., Column 3 of the Title XIX Report 701 should be $0). b. Ensure the payment system type for Medicaid and Title V on Worksheet S-2 is ***O*** (Title V will be used for uninsured payment data) c. Ensure all Level I errors are corrected. d. Ensure that Worksheet S-2 Line 25.01 is answered Yes and Line 25.02 is answered No if provider has reported residency cost. e. If provider reported residency cost, remove worksheet E-3 Part IV for Title XIX from the cost report to ensure that			

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	AUP Step	Staff Initials	W/P Ref	Comments
	interns and residents cost properly flows to the settlement worksheets. f. Ensure that Worksheet S-2 Lines 38.01 and 38.02 are answered Yes. g. If subprovider settlement data is combined with that of the main hospital, write an adjustment in Medicare Auditor to remove any Medicaid charges submitted on Worksheets D Part V and D-4 for Subprovider I or II			
6.	Determine if the provider meets **both** of the following overall DSH qualifications: a. Medicaid Day Utilization (MDU) of at least 1%. b. Obtain the names of 2 Obstetricians with staff privileges. Obtain the physician's UPIN and NPI numbers from the hospital. Log onto the Ecare website at Upin.ecare.com. Using the UPIN# determine that the physician was licensed as an Obstetrician (Rural hospitals may use physicians with any specialty as long as they have staff privileges to perform non-emergency obstetric			

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	AUP Step	Staff Initials	W/P Ref	Comments
	procedures). Determine that the physician participates in WV Medicaid by reviewing the NPI section of Upin.ecare.com. This step does not apply to hospitals that did not offer non-emergency obstetric services to the general population as of December 22, 1987.			
7.	Ensure the hospital has met the federal DSH criteria or the State defined DSH qualification criteria. If provider does not meet criteria, contact appropriate State personnel.			

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Exhibit B – Scoping and Planning Procedures

Purpose: To plan and prepare for the Agreed Upon Procedures to determine information needed to satisfy the requirements of the 42 CFR §455.204 in reviewing the State of (State Name)'s Disproportionate Share Hospital program. To review the timing and nature of the engagement with provider personnel and to make preliminary inquires.

	AUP Step	Staff Initials	W/P Ref	Comments
1.	Maintain an adjustment summary at **GP 3**, on an ongoing basis, to accumulate all proposed adjustments, by period. All adjustments which will not be made must be included on the Passed Adjustment Summary located at **GP 10**.			
2.	If this provider has been selected for an onsite review based upon the State procedures, arrange a date to begin the on site verification procedures that is mutually agreeable with provider personnel by telephone. Instruct the personnel what records will be needed to complete the procedures on-site. If feasible, inform the provider personnel of the duration of the onsite visit and how many staff members are assigned to the engagement.			
3.	Maintain documentation of written communications with provider of arrangements made in Step #2.			

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4.	Maintain throughout the engagement procedures, a "Notes to Subsequent Reviewers" for use in following cost reporting periods. These notes should include any adjustments or items which may effect the subsequent year(s). This point sheet should be included at **GP 14**.			
5.	Maintain throughout the engagement Management Points at **GP 9.** These comments should include both a description of the finding and the related recommendation.			
6.	Review the notes to subsequent reviewers from the prior year workpaper binder (include copy in workpapers) for possible material impact on the current year cost report.			
7.	If this hospital has been selected for an onsite review, maintain throughout the engagement a list of items to be followed up during the field visit.			
8.	Prepare the Engagement Planning Guide and include at **GP 8**. Conduct a planning meeting with the engagement Manager, Senior Manager, and/or Partner. Prepare budget worksheet and include at **GP 12.**			

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9.	For on-site reviews, upon arrival at the Provider's office, conduct an entrance conference with the appropriate Provider personnel to include the following: a. Determination of provider personnel who will be contacted during the course of the onsite procedures for information, explanations, documents, etc. b. Discuss the guidelines that will govern the conduct of onsite procedures. This includes the need to have records available in a reasonable time, availability of provider personnel who can answer questions and problems encountered during the verification procedure will be discussed with appropriate personnel for resolution. c. Discuss the nature of the procedures being conducted. f. Document the entrance conference and the provider's responses			
10.	Determine if provider is a transplant facility. If so, obtain Medicaid transplants by organ and uninsured by organ. Remove revenue from Wkst D-6, Part III. Also, determine if transplants were reimbursed through FFS, Medicaid Managed Care ,Out-Of-State Medicaid or Uninsured. If			

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	so, obtain support for reimbursement received by the hospital.			

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Exhibit D-Medicaid Fee for Service Settlement Data

Purpose: To determine that the Medicaid fee for service settlement data is reasonably presented in accordance with 42 CFR 447.299(c).

Important Note to Auditors: The CMS Audit Protocol states that 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 prorated to the Medicaid State plan rate year on a pro-rata basis to develop 12 full months of cost.

If data for an extra cost reporting period is necessary, obtain the following for this period:

Medicare cost report
Medicaid FFS, MCO, Dual Eligible, and Out of State charge and payment data
Uninsured Charge and Payment Data
UPL and Supplemental payments

As these periods are usually much less than a full year, our review of these partial periods will consist of compiling the data needed for the Provider Data Summary Schedule. No verification procedures will be performed on this data unless major errors are found during the full year review. Contact Manager or Senior Manager if this occurs.

	AUP Step	Staff Initials	W/P Ref	Comments
1.	Obtain the Medicaid Management Information Systems (MMIS) summary report of charges, payments and days for the facility service dates during the corresponding cost			

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	AUP Step	Staff Initials	W/P Ref	Comments
	reporting period from the State Medicaid Agency (or fiscal intermediary if applicable) that applies to the MSP rate year under review.			
2.	Review the MMIS summary report and insure that in addition to regular Medicaid fee for service payments, the data also includes the following: a. No Pay or zero paid claims (Other third party payer pays more than the entire Medicaid payment amount). b. Medicare Crossover payments. c. Third Party Payments (actual payments, not Medicaid liability). d. Coinsurance and deductible information (patient payments).			
3.	If crossover data is not available from state, obtain provider prepared inpatient and outpatient logs for those patients who were dually eligible for Medicaid and Medicare/Other Payers. Compare to MMIS data and identify and remove accounts that are duplicated in the MMIS data. For the remaining accounts, summarize charges and days by revenue code and cost center. Forward cost center totals to standard W/Ps D-6/1 and D-			

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	AUP Step	Staff Initials	W/P Ref	Comments
	6/2.			
4.	Using the FFS MMIS reports, and Medicare Crossover MMIS reports, prepare workpaper which groups covered charges and patient days by cost center. Utilize the provider prepared mapping of revenue codes by cost center to the extent it is applicable, reasonable and necessary. Refer to standard workpapers D-4/1 and D-4/2.			
6.	At standard WPs D-6/1 and D-6/2, prepare summary of Medicaid charges and days from the MMIS, and Medicaid/Medicare crossover reports or provider dual eligible logs. Also include charges and days for Medicaid MCO and Out of State Medicaid (coordinate with Exhibit E) Propose adjustments to the following cost report worksheets as necessary: a. Medicaid Inpatient ancillary charges on worksheet D-4, and Medicaid days on worksheet S-3, Part I. b. Medicaid Outpatient ancillary charges on worksheet D Part V. c. Medicaid payments and routine charges on worksheet E-3 Part III (refer to standard			

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	AUP Step	Staff Initials	W/P Ref	Comments
	WP D-6/3 for payment adjustments) Also see steps d. and e. below. d. Calculate amount of Medicare bad debt reimbursement for Medicare/Medicaid Dual Eligible patients. Obtain gross Medicare bad debts related to dual eligibles from worksheets E Part A and E Part B. Use standard w/p D-06/3 to calculate amount reimbursed by Medicare. Include reimbursed amount in Medicaid payments. Note-Medicare reimbursement rates for bad debts are 100% for Critical Access Hospitals and 70% for other hospitals. e. If the provider is a teaching hospital, calculate the amount of Medicare GME reimbursement applicable to Medicare/Medicaid Dual Eligible patients. See standard wp D-6/3. Include reimbursed amount in Medicaid Payments.			
7.	Summarize data for inclusion of IP/OP Medicaid payments and Total cost of Care for Medicaid IP/OP Services on the PDSS.			

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

Purpose: To determine that the Medicaid Managed Care and Out of State settlement data is reasonably presented in accordance with 42 CFR 447.299(c).

	AUP Step	Staff Initials	W/P Ref	Comments
1.	Identify Medicaid Managed Care Organizations that had members served by the provider during the portion of the cost reporting period that is within the MSP rate year. Ensure that all documentation has been obtained for these claims.			
2.	Identify payments from other states for Medicaid eligible patients to whom the hospital provided services during the portion of cost reporting period that is within the MSP rate year. Ensure that documentation has been obtained for all other States.			
3.	For the Medicaid out of state claims, review the Medicaid Management Information Systems (MMIS) summary report and insure that in addition to regular Medicaid fee for service payments, the data also includes the following: a. No Pay or zero paid claims (Other third party payer pays more than the entire Medicaid payment amount) b. Medicare Cross Over payments c. Third Party Payments (actual payments, not Medicaid			

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	AUP Step	Staff Initials	W/P Ref	Comments
	liability) d. Deductibles and coinsurance amounts (patient payments)			
4.	Prepare workpapers which group charges and days for Out of State Medicaid and Medicaid MCO by revenue code and cost center. Utilize the provider prepared mapping of revenue codes by cost center to the extent it is applicable, reasonable and necessary.			
5.	Summarize charge, patient day, and payment data for inclusion in the Medicaid summary workpapers at D-6/1 and D-6/2.			

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Exhibit F – Review of Uninsured Charges

Purpose: ***Determine that hospital reported accounts that meet uninsured criteria as defined in Social Security Act §1923(g)(1)(A). Verify amount for hospital reported based on 42 CFR §447.299(c)(14).***

Procedure	Initials	W/P Ref
1. Identify and remove from the uninsured detail accounts for inpatient and/or outpatient non-hospital services (excl. Skilled nursing, home health, outpatient dialysis, outpatient prescription pharmacy, dental services, etc). Separate list by inpatient and outpatient hospital services.		
2. Identify and remove from the uninsured detail any duplicate entries.		
3. Identify and remove from the uninsured detail, accounts that have a discharge dates for inpatient services or dates of services for outpatient services that are outside of the cost reporting period.		
4. Identify and remove from the uninsured detail accounts with primary payer identified.		
5. Review MMIS Report detail to remove patients included as uninsured but included on the Medicaid claims data.		
6. Identify and remove professional charges from the uninsured inpatient and outpatient hospital services.		
7. Prepare listing of inpatient and outpatient accounts that were flagged during procedures #1-6 (Reject Listing). Place reject listings on secured website and contact provider about the listing being placed on the website. Ask provider to submit documentation that demonstrates that the rejected accounts are uninsured. Communicate deadline date for provider's response. Document conversation or email in correspondence file.		

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Procedure	Initials	W/P Ref
8. Identify provider's classification as agreed upon with the State. a. Tier 1: Top two hospitals in terms of DSH payments – Proceed to procedure #9 b. Tier 2: Remaining Hospitals-Proceed to procedure #9 c. Tier 3: Bottom 40% of Hospitals in terms of DSH payments – Proceed to procedure #14		
9. Based on Clean Listing generated, select a random sample of 81 inpatient accounts (71 for review and 10 for replacements) and 81 outpatient accounts (71 for review and 10 as replacements) from the remaining population. The random sample is based upon attribute testing with a 90% confidence level and 10% margin of error, with four attributes. Upload sample listings to secured website. Communicate with provider concerning the upload of the samples, documentation needed for the samples and deadline date for documentation to ready for review. Document conversation with provider in correspondence file.		
10. Review each sample for the following: a. Evidence that the service was performed and is a covered service as defined by Medicaid State Plan. b. That amounts in provider uninsured charges detail are accurate. c. That the patient did not have insurance. d. That no professional fees are included in uninsured charges (including CRNA's). Note-This step will be performed in the field for Tier 1 hospitals.		

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Procedure	Initials	W/P Ref
11. If professional fees are identified during the review of sample, request listing of professional fees for all accounts reported on Clean Listings.		
12. Submit through secured website sample accounts rejected during review (sample errors) to provider for provider response. Communicate deadline date for response to claims removed during review of sample. Document communication in correspondence file.		
13. Review documentation concerning sample errors and determine any modification of results as needed.		
14. Review documentation supplied by provider concerning accounts listed on reject listings. Incorporate any accounts that are determined to be uninsured on clean listings and adjust charges and days by revenue code accordingly.		
15. Determine error rate of sample reviews and extrapolate error rate to Clean Listing population (Exclude from population accounts rejected during steps #1-#6. These accounts are tested outside of the statistical sample.). Refer to standard workpaper F-2.		
16. Using provider's listing of uninsured charges and days by revenue code, and the provider's mapping schedule of self pay charges and days, summarize charges and days on clean list by cost center. Prepare adjustments to the following cost report worksheets as necessary: a. Uninsured Inpatient ancillary charges on worksheet D-4, and Uninsured days on worksheet S-3, Part I. b. Uninsured Outpatient ancillary charges on worksheet D Part V. c. Uninsured payments and routine charges on worksheet E-3 Part III		

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Procedure	Initials	W/P Ref
Note-Post adjustments for uninsured data to Title V worksheets and columns.		
17. Summarize IP/OP Uninsured cost and adjust the Provider Data Summary Schedule (PDSS).		

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

Purpose: Verify payments at hospital level as required under 42 CFR §447.299(c)(12) and 42 CFR §447.299(c)(13).

Procedure	Initials	W/P Ref
1. Obtain Federal Section 1011 payments from provider or third party source documenting payments received during the cost reporting period under review. Documentation should be detailed by patient with account numbers or other identification indicator, and include primary payer information.		
2. Compile the payments for accounts that have no primary payer to determine which payments should be included as payments on uninsured. If no detail listing was provided all Federal Section 1011 payments are considered uninsured. (As criteria for excluding Section 1011 payments, see page 77916 of the Federal Register publishing 42 CFR Parts 447 and 455 for a discussion of Section 1011 payments and why they are excluded).		
3. Review working trial balance and audited financial statements for any payments received from non-third party (insurance) Payers. Examples of such payments include but not limited to: a. The Ryan White HIV/AIDS Program b. Trauma Assistance Funds Not Specifically Tied To Indigent Patients c. Victim's Assistance Funds d. Provider Created Foundations e. Tobacco Settlement Fund Not Specifically Tied To Indigent Patients		

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Procedure	Initials	W/P Ref
4. Request from provider a detail of payments received for funds identified in Step #3 by patient, including primary payer. Compile the payments for the accounts that have no primary payer to determine revenue that should be treated as Uninsured IP/OP Revenue. If no detail is provided, all revenue should be treated as Uninsured IP/OP Revenue.		
5. Summarize payments from the self pay payment listing obtained from provider that should be treated as Uninsured IP/OP Revenue.		
6. Summarize applicable Federal Section 1011 Payments and Uninsured IP/OP Revenue and adjust the Provider Data Summary Schedule (PDSS).		

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Exhibit H – Review of Miscellaneous Hospital Reporting Provisions

Purpose: Verify information at hospital level as required under 42 CFR §447.299(c)(3) through §447.299(c)(5), §447.299(c)(7), and §447.299(c)(8).

Procedure	Initials	W/P Ref
1. If hospital qualified under State Defined DSH Qualification Criteria then proceed to Step #4 otherwise complete Step #2 or Step #3 based on PDSS.		
2. Determine Medicaid Inpatient Utilization Rate based on updated Medicaid eligible days determined under review of FFS Medicaid and Non-FFS Medicaid. Divide Medicaid eligible days by total days to determine utilization rate. Total days should include both acute and sub-provider days but exclude observation days. Adjust PDSS for updated Medicaid Inpatient Utilization Rate.		
3. If Low Income Utilization Rate is reported by provider, obtain provider's documentation for charity care patients. Determine if information is reasonable and re-calculate as necessary. Adjust PDSS for updated Low Income Utilization Rate.		
4. Obtain documentation from State regarding Supplemental/Enhanced payments made to hospital for cost reporting period. Supplemental/Enhanced payments include the following: a. Upper Payment Limit Payments for inpatient and outpatient services b. Cost report settlements (tentative and/or final) c. Additional payments for graduate medical education or other special programs d. Any additional payments made for inpatient and outpatient services not covered under 42 CFR §447.299(c)(6)		

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Procedure	Initials	W/P Ref
For any payments made based on provider fiscal year as opposed to MSP rate year, allocate payment based on percentage of months of the fiscal year within the MSP rate year.(Note –this calculation will be made in the PDSS). Adjust Supplemental/Enhanced Medicaid IP/OP Payments on the Provider Data Summary Schedule.		
5. Obtain documentation from Provider or Medicaid Managed Care Organizations regarding Supplemental/Enhanced payments made to hospital for cost reporting period. Supplemental/Enhanced payments include the following: a. Upper Payment Limit Payments for inpatient and outpatient services b. Additional payments for graduate medical education c. Any additional payments made for inpatient and outpatient services not covered under 42 CFR §447.299(c)(7) For any payments made based on provider fiscal year as opposed to MSP rate year, allocate payment based on percentage of months of the fiscal year within the MSP rate year. (Note –this calculation will be made in the PDSS). Adjust IP/OP Medicaid Managed Care Organization Payments on the Provider Data Summary Schedule.		
6. Obtain documentation from Provider or Out Of State Medicaid Agencies regarding Supplemental/Enhanced payments made to hospital for MSP rate year. Supplemental/Enhanced payments include the following: a. Upper Payment Limit Payments for inpatient and outpatient services b. Cost report settlements (tentative and/or final) c. Additional payments for graduate medical education		

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Procedure	Initials	W/P Ref
d. Any additional payments made for inpatient and outpatient services not covered under 42 CFR §447.299(c)(7) For any payments made based on provider fiscal year as opposed to MSP rate year, allocate payment based on percentage of months of the fiscal year within the MSP rate year. (Note –this calculation will be made in the PDSS). Adjust IP/OP Medicaid Managed Care Organization Payments on the Provider Data Summary Schedule		
7. Summarize Disproportionate Share Hospital Payments and supplemental/enhanced Medicaid payments the provider has received from in-state Medicaid agency, Medicaid Managed Care Organizations and Out of State Medicaid Agencies		
8. Verify that DSH funds received by the providers reconcile with the amount reported as paid by the state.		
9. Verify that the state has not required providers to IGT DSH funds back to the state after disbursement.		
10. Verify with provider if any redistribution or recovery has been made based on identification of DSH payments made in excess of hospital specific limits. If so, obtain documentation from the provider that the redistribution or recovery was made based on the results of the hospital verification procedures.		

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Exhibit I – Final Report on Hospital/Completion of Procedures

Purpose: To summarize procedures completed and prepare information for the provider's cost settlement and for inclusion in review of Disproportionate Share Hospital program at the State level in accordance with 42 CFR 447.299(c).

	AUP Step	Staff Initials	W/P Ref	Comments
1.	Send the provider a copy of the adjustments. Obtain and document the provider's responses to the adjustments. **Important**- File a copy of the adjustments given to the provider at workpaper W/P I-1			
2.	Incorporate adjustments into the CMS Form 2552 software utilizing the Medicare Auditor function and produce a Level I error free cost report. Use Title V worksheets and columns for uninsured payment data. Place pdf version of reworked cost report at GP 4A.			
3.	Obtain a general representation letter signed by an appropriate provider official and dated the day procedures are completed. (GP 16)			
4.	Conduct detailed level review of adjustments			
5..	Complete Provider Data Summary Schedule (PDSS) for incorporation into review of the State Medicaid Disproportionate Share Program.			

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APPENDIX I:
SAMPLE DRAFT REPORT

This proposal includes data that shall not be disclosed outside the Government and shall not be duplicated, used, or disclosed - in whole or in part - for any purpose other than to evaluate this proposal. All data marked CONFIDENTIAL herein are subject to this restriction.

Below is the rationale for those items marked as confidential:

- *Sample Audit Program:* We are privately owned and consider specifics of our audit programs to be confidential and proprietary; therefore, our programs contained in *Appendix H: Sample Audit Program* are marked "Confidential."

- *Sample Draft Report:* We are privately owned and consider specifics of our reporting and reporting mechanisms to be confidential and proprietary; therefore, our reports contained in *Appendix I: Sample Draft Report* is marked "Confidential."

If you have any questions regarding the above, please contact Mark Hilton at 410-453-0900 or Mark.Hilton@cliftoncpa.com.

STATE OF West Virginia
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
Charleston, West Virginia

Independent Accountant's Report on
Program Operation as Related to
Disproportionate Share Hospital Payments Final Rule for
Medicaid State Plan Rate Year Ending _____

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Clifton Gunderson LLP
Certified Public Accountants & Consultants

INDEPENDENT ACCOUNTANT'S REPORT

West Virginia Department of Health and Human Resources:
Charleston, WV

We have examined management's assertion that the operation of the Disproportionate Share Hospital (DSH) Program in West Virginia (State) for the Medicaid State Plan (MSP) rate year _____ meets the requirements of each of the six verifications set forth in 42 Code of Federal Regulations (CFR) §455 relating to the Medicaid Program for Disproportionate Share Hospital Payments Final Rule (DSH Rule). The West Virginia Department of Health and Human Resources' (DHHR) management is responsible for the assertion. Our responsibility is to express an opinion on the assertion for each of the six verifications based on our examination.

Our examination was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants (AICPA) and the standards applicable to attestation engagements contained in *Government Auditing Standards*, issued by the Comptroller General of the United States and, accordingly, included examining, on a test basis, evidence supporting management's assertion and performing such other procedures as we considered necessary in the circumstances. We believe that our examination provides a reasonable basis for our opinion.

Our examination considered management's assertion on the following six verifications:

(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 MSP 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 MSP rate year, the DSH payments made in that audited MSP rate year are measured against the actual uncompensated care cost in that same audited MSP 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 Social Security 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 Social Security Act.

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(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; and any payments made on behalf of the uninsured from payment adjustments have been separately documented and retained by the State.

(6) *Verification 6:* The information specified in the preceding verification (Verification 5) includes a description of the methodology for calculating each hospital's payment limit under Section 1923(g)(1) of the Social Security Act. Included in the description of the methodology, the State has specified how it defines incurred inpatient hospital and outpatient hospital costs for furnishing inpatient hospital and outpatient hospital services to Medicaid-eligible individuals and individuals with no source of third-party coverage for the inpatient hospital and outpatient hospital services they received.

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Verification 1

Our examination disclosed _____.

In our opinion, except for the effects discussed in the preceding paragraphs, each hospital that qualifies for a DSH payment in the State is allowed to retain that payment received in accordance with 42 CFR §455.304 (d)(1) relating to the Medicaid Program's DSH Rule.

Verification 2

Our examination disclosed _____.

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

Verification 3

Our examination disclosed _____

In our opinion, except for the effects discussed in the preceding paragraph, management included only uncompensated care costs of furnishing inpatient and outpatient hospital services to Medicaid-eligible individuals and individuals with no third-party coverage for the inpatient and outpatient hospital services as eligible costs in the calculation of the hospital-specific DSH payment limit in accordance with 42 CFR §455.304 (d)(3) relating to the Medicaid Program's DSH Rule.

Verification 4

Our examination disclosed _____.

In our opinion, except for the effects discussed in the preceding paragraph, all Medicaid payments, that are in excess of the Medicaid-incurred costs of such services, are applied against the uncompensated care costs of furnishing inpatient hospital and outpatient hospital services to individuals with no source of third-party coverage for such services in accordance with 42 CFR §455.304 (d)(4) relating to the Medicaid Program's DSH Rule.

Verification 5

Our examination disclosed _____.

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

Verification 6

Our examination disclosed _____.

In our opinion, except for the effects discussed in the preceding paragraph, management included in the information and records it retained a description of the methodology for calculating each hospital's DSH payment limit and definitions of incurred inpatient and outpatient costs in accordance with 42 CFR §455.304 (d)(6) relating to the Medicaid Program's DSH Rule.

In accordance with *Government Auditing Standards*, we have also issued our report dated

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_____, on our consideration of DHHRs' internal controls over the DSH Program in the State for the MSP rate year ____ as it relates to the six verifications set forth in 42 CFR §455 relating to the Medicaid Program's DSH Rule. The purpose of that report is to describe the scope of our testing of internal controls over the DSH Program in the State for the MSP rate year ____ as it related to the aforementioned six verifications set forth in the DSH Rule and the results of that testing, and not to provide an opinion on the internal controls over compliance with the DSH Rule. That report is an integral part of an examination performed in accordance with *Government Auditing Standards* and should be considered in assessing the results of our examination.

This report is intended solely for the information and use of DHHR and is not intended to be, and should not be, used by anyone other than these specified parties.

Clifton Gunderson LLP

Baltimore, Maryland
Date

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Clifton Gunderson LLP
Certified Public Accountants & Consultants

INDEPENDENT ACCOUNTANT'S REPORT ON INTERNAL CONTROL OVER THE DISPROPORTIONATE SHARE HOSPITAL PROGRAM IN WEST VIRGINIA FOR THE MEDICAID STATE PLAN RATE YEAR ____ AS RELATED TO THE SIX VERIFICATIONS SET FORTH IN 42 CFR §455 DISPROPORTIONATE SHARE HOSPITAL PAYMENTS FINAL RULE

West Virginia Department of Health and Human Resources:
Charleston, West Virginia

We have examined the assertion of DHHR that operation of the DSH Program in the State for the MSP rate year ____ followed the requirements of the six verifications set forth in 42 CFR §455.304 relating to the DSH Rule. We conducted our examination in accordance with the attestation standards established by AICPA and the standards applicable to attestation engagements contained in *Government Auditing Standards*, issued by the Comptroller General of the United States.

In planning and performing our examination, we considered DHHR's internal controls over the DSH Program, in order to determine our examination procedures for the purpose of expressing our opinion on management's assertion related to the six verifications set forth in the DSH Rule and not to provide an opinion on the internal controls over compliance with the DSH Rule. Accordingly, we do not express an opinion on the effectiveness of DHHR's internal control over compliance with the DSH Rule.

A control deficiency exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent or detect misstatements on a timely basis. A significant deficiency is a control deficiency, or combination of control deficiencies, that adversely affects the entity's ability to initiate, authorize, record, process, or report financial data reliably such that there is more than a remote likelihood that noncompliance with the six verifications set forth in the DSH Rule that is more than inconsequential will not be prevented or detected by the entity's internal control. We consider the deficiencies described in the accompanying Schedule of Findings to be significant deficiencies in internal control in relation to the six verifications set forth in the DSH Rule.

A material weakness is a significant deficiency, or combination of significant deficiencies that results in more than a remote likelihood that a material deviation from the requirements of the six verifications set forth in the DSH Rule will not be prevented or detected by the entity's internal controls. Of the significant deficiencies described above, we consider findings ____ to be material weaknesses.

Our consideration of internal control relating to the six verifications set forth in the DSH Rule was for the limited purpose described in the first paragraph of this section and would not necessarily identify all deficiencies in internal control that might be significant deficiencies or material weaknesses.

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Compliance and Other Matters

As part of obtaining reasonable assurance about whether the assertion by DHHR that the operation of the DSH program in the State met the requirements of the six verifications set forth in the DSH Rule is free of material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, and contracts, noncompliance with which could have a direct and material effect on the compliance with the six verifications set forth in the DSH Rule. However, providing an opinion on compliance with those provisions was not an objective of our examination, and accordingly, we do not express such an opinion. The results of our tests disclosed instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards* and which are described in the accompanying Schedule of Findings as Findings ____.

This report is intended solely for the information and use of DHHR and is not intended to be, and should not be, used by anyone other than these specified parties.

Clifton Gunderson LLP

Baltimore, Maryland
Date

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WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES SCHEDULE OF FINDINGS RELATING TO THE SIX VERIFICATIONS OF THE DISPROPORTIONATE SHARE HOSPITAL PAYMENTS FINAL RULE FOR THE MEDICAID STATE PLAN RATE YEAR ____

Finding 1 –

Criteria

Condition

Recommendation

Finding 2 –

Criteria

Condition

Recommendation

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Disproportionate Share Hospital Data Reporting Form

Confidential -
Not for Distribution

Department of Health and Human Resources Response to Findings

Confidential -
Not for Distribution

STATE OF WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
DISPROPORTIONATE SHARE HOSPITAL DATA REPORTING FORM

	1	2	3	4	5	6	7	8
Hospital Name	State Estimated Hospital-Specific DSH Limit	Medicaid IP Utilization Rate	Low-Income Utilization Rate	State-Defined DSH Qualification Criteria	Regular IP/OP Medicaid FFS Basic Rate Payments	IP/OP Medicaid MCO Payments	Supplemental/ Enhanced IP/OP Medicaid Payments	Total Medicaid IP/OP Payments
								$ -
								$ -
								$ -
								$ -
								$ -
								$ -
								$ -
								$ -
								$ -
								$ -
								$ -
Institutes for Mental Disease								
								$ -
								$ -
								$ -
								$ -
Out-of-State DSH Hospitals								
								$ -
								$ -
								$ -
								$ -
								$ -
								$ -
								$ -

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MEDICAID STATE PLAN RATE YEAR ____

STATE OF WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
DISPROPORTIONATE SHARE HOSPITAL DATA REPORTING FORM

	9	10	11	12	13	14	15	16
Hospital Name	Total Cost of Care - Medicaid IP/OP Services	Total Medicaid Uncompensated Care	Uninsured IP/OP Revenue	Total Applicable Section 1011 Payments	Total cost of IP/OP Care for the Uninsured	Total Uninsured IP/OP Uncompensated Care Cost	Total Annual Uncompensated Care Costs	Disproportionate Share Hospital Payments
		$ -				$ -	$ -	
		$ -				$ -	$ -	
		$ -				$ -	$ -	
		$ -				$ -	$ -	
		$ -				$ -	$ -	
		$ -				$ -	$ -	
		$ -				$ -	$ -	
		$ -				$ -	$ -	
		$ -				$ -	$ -	
		$ -				$ -	$ -	
		$ -				$ -	$ -	
Institutes for Mental Disease								
		$ -		$ -		$ -		
		$ -		$ -		$ -	$ -	
		$ -		$ -		$ -	$ -	
		$ -		$ -		$ -	$ -	
Out-of-State DSH Hospitals								

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MEDICAID STATE PLAN RATE YEAR ____

APPENDIX J:
PROFESSIONAL RESUMES

MARK K. HILTON, CPA
Partner

Professional Certifications

Certified Public Accountant - Maryland, Pennsylvania, and Virginia

Education

Bachelor of Science degree with a major in accounting, Liberty University, 1982

Years of Experience

26 years

Areas of Specialization

- Health care auditing and accounting with an emphasis on Medicaid and/or Medicare reimbursement relating to hospitals, residential treatment centers, federally qualified health centers, intermediate care facilities (alcoholic type D facilities), skilled nursing facilities, outpatient rehabilitation facilities, home health agencies, intermediate care facilities for the mentally retarded, end-stage renal dialysis facilities, and home offices
- Health care consulting with an emphasis on fraud investigation and litigation support

Relevant Experience

State of South Carolina - Disproportionate Share (DSH) Program and Hospital Cost settlements (2006-present)

- Partner responsible for overseeing the contract with the Department of Health and Human Services to perform audit procedures on the State of South Carolina Disproportionate Share Hospital Payment Program. Responsibilities include modification of audit program, scheduling, reviewing completed engagements, supervising staff, interaction with state and hospital representatives. Partner responsible for performing Medicaid cost settlements on South Carolina hospitals. Responsibilities include cost settlement program development, scheduling, reviewing of completed workpapers, supervising staff , and interaction with state and hospital representatives.

State of New Hampshire - Disproportionate Share (DSH) Program audits (2009-present)

- Partner responsible for overseeing the contract with the New Hampshire Department of Health and Human Services to perform audit procedures on the State of New Hampshire Disproportionate Share Hospital Payment Program. Responsibilities include modification of audit program, scheduling, reviewing completed engagements, supervising staff, interaction with state and hospital representatives.

State of Oregon - Disproportionate Share (DSH) Program audits (2009-present)

- Partner responsible for overseeing the contract with the Oregon Department of Human Services, Division of Medical Assistance Services to perform audit procedures on the State of New Hampshire Disproportionate Share Hospital Payment Program. Responsibilities include modification of audit program, scheduling, reviewing completed engagements, supervising staff, interaction with state and hospital representatives.

District of Columbia - Disproportionate Share (DSH) Program audits (2009-present)

- Partner responsible for overseeing the contract with Williams, Adley & Company, the CPA firm contracted by the District of Office of the Chief Financial Officer for Medicaid Audits to perform audit procedures on the District of Columbia Disproportionate Share Hospital Payment Program. Responsibilities include modification of audit program, scheduling, reviewing completed engagements, supervising staff, interaction with state and hospital representatives.

State of Maryland Department of Health and Mental Hygiene - Medicaid Program (1983-2006)

- Successfully managed the coordination of the hospital, residential treatment centers, federally qualified health centers, intermediate care facilities for the mentally retarded, intermediate care - alcoholic type D facilities, and home health agency cost report verifications. This included scheduling of fieldwork, reviews of verifications and appeal position papers, development of quality control and internal training programs, and interaction with Program personnel.
- Provided litigation support services for Medicaid cost report appeals. Analyzed appeal issues, prepared hearing exhibits, provided hearing testimony and assisted with settlement negotiations. Testified as expert witness in healthcare accounting and Medicare and Medicaid reimbursement before the State of Maryland Office of Administrative Hearings. Researched and prepared position papers for presentation to the State of Maryland Hospital Appeal Board.

Commonwealth of Virginia Department of Medical Assistance Services (1994)

- Responsible for completion of Virginia Medicaid cost report audits for a children's hospital and an intermediate care facility for the mentally retarded. Responsibilities included pre-field coordination, review of field work, and report preparation.

City of Baltimore, Maryland Municipal Health Services Program (1992-1994)

- Successfully managed the coordination of audits of Baltimore City clinics that participate in the Municipal Health Services Program. This included supervision of personnel, review of workpapers, and interaction with personnel of the clinic, Baltimore City Health Department, and CMS.

U.S. Department of Justice (DOJ) (1997-present)

- Partner responsible for the oversight of the FBI Headquarters' Health Care Fraud Unit subcontract involving litigation support and the investigation of health care fraud cases across the United States. Provided litigation support assistance to FBI Special Agents, FBI Financial Analysts, Assistant United States Attorneys, U.S. DOJ Commercial Litigation Trial Attorneys, State Attorneys, Chief Investigators of Medicaid Fraud Control Units, U.S. Department of the Treasury Special Agents, U.S. Department of Treasury Intelligence Analysts, U.S. Food and Drug Administration Office of Criminal Investigations Special Agents, U.S. Department of Health and Human Services Office of Inspector General Special Agents, National Insurance Crime Bureau Agents, and Government Statisticians and Medical Experts.
- Partner responsible for providing litigation support services to the Department of Justice Assistant United States Attorneys and attorneys

representing the Commercial Litigation Branch of the U.S. Department of Justice Civil and Criminal Divisions relating to healthcare fraud investigations. Analyzes and researches complex reimbursement issues and provides support for damage calculations. Entities investigated include hospitals, clinics, pharmacies, medical transcription agencies, durable medical equipment suppliers, among others. Experienced with Microsoft Access in developing and analyzing large financial and statistical databases. Provides assistance with witness depositions including development of questioning strategy, analysis of witness testimony and preparation of exhibits. Experienced with maintaining and managing large inventories of case documents.

Presentations and Publications

- "Medicare and Community Mental Health Centers," Colorado Mental Health Center and Clinics Association, Annual Conference; and Colorado Mental Health Associates, Annual Business Manager's Conference
- "Medicare Reimbursable Bad Debts," and "Medicare Graduate Medical Education," District of Columbia Hospital Association
- Medicaid Disproportionate Share Hospital Audits", South Carolina Hospital Association and State of South Carolina, National Association of State Human Service Finance Officers (HSFO) annual training conference and Spring Planning and Business Meeting, Mississippi Hospitals for the Mississippi Medicaid Division, New Hampshire Hospitals for the New Hampshire Medicaid Division
- Clifton Gunderson Technical Sessions
  - "Medicaid Cost Reporting"
  - "Medicaid Settlement Data"
  - "Medicaid Audit & Reimbursement Issues"
  - "Health Care Fraud"
  - "Medicaid Disproportionate Share Hospital Audits"
- Clifton Gunderson Health Care Conference
  - "Medicare - Part A and Part B"
  - "Medicare/Medicaid Auditing"
  - "Medicare/Medicaid Reimbursement"
  - "Medicare - Home Offices"
  - "Using the Internet for Health Care Research"

Professional Affiliations

- American Institute of Certified Public Accountants - member
- Virginia Society of Certified Public Accountants - member
- American Health Lawyers Association - member
- Association of Government Accountants - member

Civic and Social Affiliations

Grace Bible Baptist Church – past treasurer, bond manager, deacon, teacher

Honors and Awards

- Clifton Gunderson LLP Founders' Award - Neal E. Clifton Professionalism Award - 2003
- Named by *SmartCEO Magazine* as one of Maryland's top CPAs - 2004

ROBERT M. BULLEN, CPA, CFE
Partner

Professional Certifications

- Certified Public Accountant - Maryland, Virginia, North Carolina, New Jersey and Massachusetts
- Certified Fraud Examiner

Education

Bachelor of Science degree with a major in accounting,
University of Baltimore, 1983

Years of Experience

25 years

Areas of Specialization

- Health care auditing and accounting services with an emphasis on Medicaid and Medicare reimbursement, and compliance audits of providers and their home offices
- Financial related audits of Managed Care Organizations
- Health care litigation support services
- Regulatory consultation services
- Performance audits

Relevant Experience

State of North Carolina - Department of Health and Human Services (2007-present)

- Partner responsible for overseeing the contract with North Carolina Medicaid to perform cost report audits and agreed upon procedures of nursing facilities, non-public critical access hospitals, freestanding rural health clinics, hospital-based rural health clinics, teaching hospitals, federally qualified health centers, physician practice plans of teaching hospitals, state-owned psychiatric hospitals, state-owned intermediate care facilities for the mentally retarded, and state-owned nursing facilities. Responsibilities include reviewing completed engagements, supervising staff, interaction with Division of Medical Assistance personnel and report preparation.

**Centers for Medicare & Medicaid Services (CMS)
(2005-present)**

- Partner responsible for overseeing the contract with the Division of Capitated Plan Audits to perform examinations of 2005 Adjusted Community Rate Worksheets prepared by nineteen Medicare Advantage Organizations. Responsibilities include modification of examination program, scheduling, reviewing completed engagements, supervising staff, interaction with health plan and CMS personnel and report preparation.
- Partner responsible for overseeing the contract with the Division of Capitated Plan Audits to perform Agreed Upon Procedures financial reviews of Medicare Part D Prescription Drug Plans.
- Partner responsible for overseeing the contract with the Office of Research, Development and Information to perform an Agreed Upon Procedures Review of a disease management organization to validate operational procedures and expenditures relating to their participation in the BIPA Disease Management Demonstration
- Partner responsible for overseeing the subcontract with Granite Dolphin

Actuarial Services to perform examinations of bid forms submitted by Medicare Advantage and Prescription Drug Plan sponsors for the 2007 contract period for the Centers for Medicare and Medicaid Services, Office of the Actuary

- Partner responsible for overseeing the contract with the Office of the Actuary to perform examinations of bid forms submitted by Medicare Advantage and Prescription Drug Plan sponsors for the 2006 contract period. Broad areas examined included base period data, projection of base period data to the contract year, non-medical costs and components of resulting bid for the contract year.
- Partner responsible for overseeing the contract with the Center for Beneficiary Choices, Medicare Advantage Group to perform examinations of 2004 Adjusted Community Rate Worksheets prepared by ten Medicare Advantage Organizations

U.S. Department of Justice (2006-present)

- Health Care Litigation Support Services for the United States Attorneys' Office in the District of Colorado

State of Kansas Department of Social and Rehabilitation Services (2006)

- Partner responsible for overseeing the agreed upon procedures review of the Medicaid Rehabilitative Treatment claiming and reporting process for Child Welfare, Family Preservation and Targeted Case Management

State of Maryland Department of Health and Mental Hygiene - Medicaid Program (1983-2006)

- Successfully managed the administrative aspects of the contract as well as coordination of the nursing home cost report verifications. This includes scheduling of fieldwork, reviews of verifications and appeal position papers, development of quality control and internal training programs, and interaction with Program personnel.

State of Maryland HealthChoice Program (2002-2006)

- Successfully managed the annual agreed upon procedures engagements of all Managed Care Organizations that participate in the State of Maryland HealthChoice program. These engagements include the review of medical and administrative expenditures as well as the issuance of reports for each MCO reporting the findings of our procedures.

Maryland Health Care Commission (2001-present)

- Partner responsible for overseeing audits of Reimbursement applications submitted to the Maryland Trauma Physician Services Fund administered by the Maryland Health Care Commission. The Fund provides reimbursement to trauma physicians for uncompensated care provided to trauma patients. The Fund also reimburses trauma centers for expenses associated with having trauma physicians on-call and available to provide trauma care.

City of Baltimore - Maryland Municipal Health Services Program (1992-2007)

- Successfully managed the coordination of audits of Baltimore City clinics that participate in the Municipal Health Services Program. This includes supervision of personnel, review of workpapers, and interaction with personnel of the clinic, Baltimore City Health Department, and CMS.

City of San Jose, California - Municipal Health Services Program (1998-2007)
Successfully managed the coordination of audits of clinics that participate in the program. This includes supervision of personnel, review of workpapers and interaction with personnel of the clinic, City of San Jose MHSP, and CMS.

City of Milwaukee - Municipal Health Services Program (2001-2007)

- Successfully managed the coordination of audits of clinics that participate in the program

State of Maryland - Developmental Disabilities Administration (1995-present)

- Responsible for completion of annual cost reports for Baltimore and Washington, DC office not-for-profit clients

Commonwealth of Virginia (1994-present)

- Coordinated and supervised Medicaid cost report audits

Centers for Medicare & Medicaid Services - Philadelphia Regional Office (1991-1994)

- Successfully managed the State Performance Evaluation and Comprehensive Test of Reimbursement Under Medicaid (SPECTRUM) of Long Term Care Facilities in West Virginia
- Successfully managed the SPECTRUM review of private nursing homes and acute care hospitals in Delaware
- Project director for the review of Medicaid reimbursable costs at state-operated long term care facilities in the District of Columbia and Virginia

Centers for Medicare & Medicaid Services - New York Regional Office (1990)

- Team leader for the SPECTRUM review of the New Jersey Medical Assistance Program

State of Montana (1988-1989)

- Coordinated the Medicaid cost report audits of 33 nursing homes

State of Indiana Department of Public Welfare (1986-1990)

- Supervised cost report audits

Presentations and Publications

- Healthcare Financial Management Association Regulatory Update "Maryland Medicaid Nursing Home Payment System", Ellicott City, Maryland
- Health Facilities Association of Maryland Regulatory Update, Baltimore, Maryland

Professional Affiliations

- American Institute of Certified Public Accountants - member
- Maryland Association of Certified Public Accountants - member
- American Health Lawyers Association - member
- Association of Certified Fraud Examiners - member

Civic and Social Affiliations

- The Leukemia & Lymphoma Society, Maryland Chapter - committee member
- The Woods at Old Harford Homeowners Association - treasurer

JOHN D. KRAFT, CPA, CHFP

Senior Manager

Professional Certifications

- Certified Public Accountant - Maryland
- Certified Healthcare Financial Professional, Managed Care

Education

Bachelor of Science degree with a major in accounting and economics, Towson University, 1986

Years of Experience

23 years

Areas of Specialization

- Health care auditing, accounting and consulting, with an emphasis on Medicaid and Medicare reimbursement for hospitals, health agencies federally qualified health centers, residential treatment centers, alcohol/drug treatment centers, and ICF/MRs
- Health care consulting with an emphasis on fraud investigation and litigation support

Relevant Experience

State of South Carolina Department of Health and Human Services- Medicaid Program (2006-present)

- Manages and reviews field audits and desk reviews of hospital Medicare cost reports and Disproportionate Share Hospital (DSH) statistical data. Key participant in developing DSH and Medicaid cost settlement audit and desk review programs and engagement planning guides. Developed Microsoft Excel spreadsheets to calculate Medicaid cost settlements, and to summarize hospital uncompensated care costs, hospital-specific DSH payment limits and DSH qualification criteria. Experienced with HFS Medicare cost reporting software.

U.S. Department of Justice (1999-present)

- Provides litigation support services for healthcare fraud investigations. Analyzes and researches complex reimbursement issues and provides support for damage calculations. Entities investigated include hospitals, clinics, pharmacies, medical transcription agencies, durable medical equipment suppliers, among others. Experienced with Microsoft Access in developing and analyzing large financial and statistical databases. Provides assistance with witness depositions including development of questioning strategy, analysis of witness testimony and preparation of exhibits. Experienced with maintaining and managing large inventories of case documents.

State of Maryland Department of Health and Mental Hygiene - Medicaid Program (1986-2006)

- Managed and reviewed field audits and desk review verifications of hospitals, ICF/MRs, residential treatment centers, alcohol/drug treatment centers, home health agencies, federally qualified health centers and nursing homes. Established departmental objectives and managed the workload of a large staff of audit professionals. Developed detailed audit, desk review and interim rate calculation programs and engagement planning guides for a number of provider types. Monitored Medicare and Medicaid regulatory environment and updated programs and procedures. Reviewed TEFRA target rate

adjustment requests for Maryland Medicaid providers.

State of Maryland Department of Health and Mental Hygiene - Medicaid Program (1993-present)

- Provides litigation support services for Medicaid cost report appeals. Analyzes appeal issues, prepares hearing exhibits, provides hearing testimony and assists with settlement negotiations. Testified as expert witness in healthcare accounting and Medicare and Medicaid reimbursement before the State of Maryland Office of Administrative Hearings. Researched and prepared position papers for presentation to the State of Maryland Hospital Appeal Board.

Centers for Medicare & Medicaid Services (CMS)
(1990, 1997-1999)

- Reviewed and evaluated financial audit work of the Tennessee, Massachusetts and Pennsylvania state Medicaid programs in conjunction with CFO Act audit of financial statements
- Key participant in the State Performance Evaluation and Comprehensive Test of Reimbursement Under Medicaid (SPECTRUM) of the state of New York for CMS

Commonwealth of Virginia - Medicaid Program (1995-1996)

- Managed field audits of children's and acute care hospitals' Medicaid cost reports

State of Maryland - Office of Legislative Audits
(1991-1992)

- In-charge auditor. Supervised the work of one to three assistants in the review and evaluation of the internal control structures of various state agencies as well as the assessment of compliance with state laws and regulations.

State of Montana - Medicaid Program (1988-1989)

- In-charge of full-scope verifications of nursing home Medicaid cost reports

General:

Medicare (1992-1993)

- Supervised Medicare field audits and desk reviews for the Maryland Medicare intermediary

Nonprofit Healthcare (1990-1996)

- Managed and reviewed financial statement audits, cost report audits and grant report compilations for nonprofit healthcare organizations. Conducted reimbursement analysis and consulting

Presentations and Publications

- Presentation at South Carolina Hospital Association-Disproportionate Share Hospital Audit and Reporting Rule Conference, March 2009
- Presentation at Clifton Gunderson Training Session-South Carolina DSH & Cost Settlement Reviews, August 2008
- Presentation at Clifton Gunderson Training Session -Understanding DSH, February 2006

- Presentation at Clifton Gunderson Core II Training - Overview of State of Maryland, Medicaid Reimbursement Systems for Hospitals and Nursing Homes, June 2002

Professional Affiliations

- American Institute of Certified Public Accountants - member
- Maryland Association of Certified Public Accountants - member
- Healthcare Financial Management Association - member
- American Health Lawyers Association - member

Civic and Social Affiliations

- Towson University Accounting Advisory Board, 2005-present
- Liberty-Owings Mills Exchange Club, 1994-2004

Honors and Awards

Named the national high scorer for the 1998-1999 HFMA Managed Care Examination

HUGH L. WEBSTER

Senior Manager

Education

Bachelor of Science in Accounting,
Auburn University, 1977

Years of Experience

31 years

Areas of Specialization

- Medicaid/SCHIP agency performance
- State Medicaid/SCHIP quarterly budget and expenditure reports
- Complex funding mechanisms (CPE, IGT, taxes, donations)

Relevant Experience

Centers for Medicare & Medicaid Services Manager, Medicaid/ SCHIP Financial and Program Operations, Division of Medicaid and Children's Health, Atlanta Regional Office, (1997-2008)

- Managed the financial and program operation activities of 32 staff assigned to eight Region IV states (NC, SC, TN, KY, MS, AL, GA, FL) including:
  - Reviews of all institutional and non-institutional State Plan Amendments.
  - Reviews of State's Medicaid/SCHIP Qtly Budget and Expenditure Reports.
  - Reviews of funding mechanisms such as donations, taxes, certified public expenditures, intergovernmental transfers, state and local appropriations.
  - Reviews to resolve DHHS and General Accounting Office (GAO) audit reports of State Medicaid/SCHIP agency performance.
  - Reviews of State agency MMIS/Managed care contracts for FFP.
  - Development of review guides to supplement established financial management (FM) review processes.
  - Reviews of Cost Allocation Plans submitted through DCA.
- Acting Associate Regional Administrator of the Division of Medicaid and Children's Health for 7 months in 2003.

Health Care Financing Administration (HCFA)
State Financial Analyst, Medicaid Financial Mgt Branch
Division of Medicaid, Atlanta Regional Office, (1983-1997)

- Assigned responsibility at one time or another for the States of Georgia, North Carolina, Tennessee, Alabama, South Carolina, and Mississippi. Nationally known and recognized for knowledge of institutional reimbursement issues such as UPL and DSH and issues that deal with HIPAA, MMIS, cost allocation plans, financial aspects of 1115 demonstration waivers, prepaid health plans, and tax and donation programs. Served on several central office workgroups such as the UPL regulation team, SCHIP payment and allotment team, and Medicaid financial management team.

General Accounting Office (GAO), Program Evaluator
Finance and Accounting Program Group, Atlanta Regional Office, (1980-1983)

- Conducted audits of HCFA, U.S. Parole Commission, and U.S. Air Force

Professional Affiliations	• National Association of State Human Services Finance Officers • National Association of State Medicaid Directors
Civic and Social Affiliations	AOPA, KA Fraternity

WILLIAM DAVID MOSLEY, MBA

Partner / Assistant Director of Governmental Services

Education

- Bachelor of Science degree with a major in finance, Auburn University, 1990
- Masters degree in business administration and organizational development, Auburn University, 1991
- Certificate in public policy, Arizona State University, 1993

Years of Experience

15 years

Areas of Specialization

- Providing government agencies and elected officials with concise, well-founded guidance relating to policy development and the ongoing operational compliance of complex programs
- Facilitating open, mutually advantageous dialogue between state clients and Federal regulators
- Providing insight on current trends, regulations, and Congressional activities relating to the administration of essential government programs

Relevant Experience

State of Mississippi - Office of the Governor, Division of Medicaid (2006-present)

- Provide expert testimony, consulting, and analysis services on a myriad of Medicaid reimbursement issues including complex hospital reimbursement, Federal reporting, provider taxes, cost reporting, eligibility, and performance auditing.

State of Mississippi – Department of Human Services (2008-present)

- Conduct a performance analysis and risk assessment relating to the Department's use of Federal funds from various sources, coordination with the Medicaid program, and best practices

State of Alabama- Division of Medicaid (2007-present)

- Assist the State with CMS negotiations regarding CPE settlement protocol, conducting hospital-specific settlements, provider tax feasibility analysis, and policy consultation

State of Tennessee Bureau of TennCare (2004-2007)

- Conduct detailed, annual comparative analysis of hospital reimbursement methodology for the State of Tennessee

State of Kansas - Department of Social and Rehabilitative Services (SRS) (2006-2008)

- Establish administrative service cost component for new prepaid ambulatory health plan covering Medicaid mental health services

State of North Carolina - Division of Medical Assistance (2006)

- Provided a detailed rate analysis to determine the inflationary cost incurred by all provider groups serving Medicaid enrollees in the State

State of South Carolina – Department of Health and Human Services (2006-present)

- Led a Clifton Gunderson team in the first audit of state Disproportionate Share Hospital procedures pursuant to new CMS requirements and continues to provide technical support

Texas Health and Human Services Commission (2004)

- Led Clifton Gunderson team on risk assessment and performance audit of MMIS $90 million contract

State of North Carolina - Division of Medical Assistance (2001-2004)

- Served as Assistant Director of Financial Management; Accepted appointment by the Secretary of DHHS. Responsibilities included:
  - Reengineering of all financial aspects of a $9 billion health insurance program with 65,000 providers and 1.6 million annual recipients
  - Rate Setting, Audit, and Management Information System sections were direct reports

Professional Affiliations

- Chamber of Commerce – member
- American Hospital Association - member
- American Economic Development Council – elected member
- American Management Association - member
- Financial Management Association – member

DAVID MCMAHON, II, CPA

Senior Manager

Professional Certifications

- Certified Public Accountant - North Carolina
- Certified Public Accountant - South Carolina

Education

- Bachelor of Science in business administration with concentrations in accounting and finance, Winthrop University, 1994

Years of Experience

14 years

Areas of Specialization

- Cost Report Knowledge of Issues Including Graduate Medical Education, Transplant, Home Office
- Medicare audits of hospitals
- Audits of hospital uninsured claims for the Disproportionate Share Hospital (DSH) program
- Reconciling Certified Public Expenditures (CPE)
- Health care auditing and accounting with an emphasis on Medicaid and Medicare reimbursement

Relevant Experience

Technical Advice for Various Contracts Held By Clifton Gunderson with State Medicaid Agencies (2005-present)

- Research topics ranging from definition of hospital services under Medicaid to definition of uninsured and assist in development of position statements for the various offices.
- Provided on-site assistance and guidance for work performed for the State of Texas related to its Disproportionate Share Hospital Payment program.
- Provided on-site assistance and guidance for work performed for the State of Nevada related to its Disproportionate Share Hospital Payment program.
- Provided on-site assistance and guidance for work performed for the State of Mississippi related to its Hospital Services reimbursement programs.

North Carolina Division of Medical Assistance (2005-present)

- Perform audits of large complex hospital facilities.
- Develop audit programs for home office operations and physician cost reporting.
- Provide guidance on various reimbursement issues as needed for staff of the North Carolina DMAS.

North Carolina Division of Medical Assistance For CPE Settlement Review (2008-present)

- Senior Manager responsible for the completion of reviewing CPE Settlement of the 43 Public Hospitals for State Fiscal Year 2006 Disproportionate Share Hospitals Payment program.
- Assisted in the design of agreed upon procedures program and establishment of

standard workpapers related to the project.

Alabama Medicaid Agency (2008-present)

- Develop and perform agreed-upon procedures engagement to reconcile Certified Public Expenditures (CPEs) claimed by the Alabama Medicaid Agency for federal reimbursement. This includes reviewing the allowability of claims under the Disproportionate Share Hospital (DSH) program, a review of the Medicare Cost-to-Charge Ratio and an examination of the uninsured claims.
- Perform training of staff related to procedures developed for the project.

South Carolina Department of Health and Human Services (2006-present)

- Develop various audit programs for Disproportionate Share Hospital (DSH) audit contract with the South Carolina Department of Health and Human Services.
- Supervise on-site engagements conducted under the DSH contract.

Academic Teaching Hospital (1999-2005)

- Supervised the completion of Medicaid cost reports for 4 fiscal years for Academic Teaching Hospital with over $1 Billion of gross revenue in the final cost reporting period.
- Completed appeals and reconsideration reviews for settled Medicaid and Medicare cost reports.
- Liaison with both Medicare and Medicaid representatives regarding cost report audits, appeal filings and other Reimbursement related issues.

Palmetto Government Benefits Administrators (1994-1999)

- In-charge auditor for various Medicare field reviews of home health agencies, skilled nursing facilities and home office operations in several states for Palmetto Government Benefits Administrators.
- Performed and review Medicare desk audit reviews of home health agencies for Palmetto Government Benefits Administrators.
- Designed training structure for department of 75 auditors at Palmetto Government Benefits Administrators' Columbia office.
- Developed home office training manual for Medicare Audit department and conducted training session on the manual for 57 auditors at Palmetto Government Benefits Administrators' Columbia office.
- Created automated desk audit review programs for home health agency and home office reviews performed by Palmetto Government Benefits Administrators.

Presentations and Publications

- Problem Solving Trainer for Palmetto Government Benefits Administrators, 1998-1999
- Various Training Sessions on Cost Reports and Medicare Regulations for Palmetto Government Benefits Administrators Medicare Audit staff, 1996-1999
- *Cost Report 101*, Presented to Clifton Gunderson Team Healthcare Retreat, Des Moines, IA, October 2007.
- *Cost Report Audit Training*, Presented to CMS Medicare Part A Cost Reports Staff,

Baltimore, MD, May 2008.

- *Hospital Training Session*, Presented to Clifton Gunderson Team Healthcare Indianapolis Staff, Indianapolis, IN, July 2008.

Professional Affiliations

- South Carolina Association of Certified Public Accountants – member

DIANE B. KOVAR, CPA

Manager

Professional Certifications

Certified Public Accountant - Maryland

Education

Bachelor of science degree with a major in accounting,
Pennsylvania State University, 1998

Years of Experience

10 years

Areas of Specialization

Health care auditing and accounting with an emphasis on Medicaid and Medicare reimbursement

Relevant Experience

State of Maryland Department of Health and Mental Hygiene – Medicaid Program (2001-2006)

- Conducts desk reviews and field audits of federally qualified health centers, residential treatment centers, psychiatric hospitals, state facilities, and alcohol/drug treatment centers
- Conducts Medicare focused reviews and desk reviews of hospitals, skilled nursing facilities, and rehabilitation facilities

State of South Carolina - Department of Health and Human Services - Medicaid Program (2006-present)

- Perform verifications of Disproportionate Share (DSH) claims data submitted by hospitals to the State of South Carolina, Department of Health and Human Services in order to validate DSH payments made to the hospital providers

City of San Jose, California - Municipal Health Services Program (2001-present)

- Performs audit of cost reports

Centers for Medicare & Medicaid Services (CMS) (2000-present)

- Assisted in the planning, directing, and completing the CMS CFO audit (FY 2000-2004)
- Assisted in the planning, directing and completing the FY 2001 CMS accounts receivable engagement (AdminaStar Federal - Cincinnati, Ohio)
- Participated in a CMS SAS-70 of a Medicare contractor in FY 2003 - FY 2006
- Participated in a CMS accounts receivable agreed-upon procedures of a Medicare contractor (FY 2003-2005)
- Participated in a CMS Medicare Advantage and/or Prescription Drug bid plan audit (FY 2005 - FY 2006)

U.S. Department of Justice (2001-present)

- Provides litigation support

Professional Affiliations

- American Institute of Certified Public Accountants - member
- Maryland Association of Certified Public Accountants - member

MEHYANG HANKS
Manager

Education	Bachelor of Economics degree with a major in accounting, University of California at Los Angeles, 1997
Years of Experience	10 years
Areas of Specialization	Health care auditing and accounting with an emphasis on Medicaid and Medicare reimbursement
Relevant Experience	**Wellpoint/National Government Services LLC (1997-2008)** • Audit Supervisor responsible for providing technical direction and training both in a formal and informal setting. Makes accounting decisions relative to audits, conferring, when necessary. Handle complex case researches and advises on complex cases for providers, CMS and BCBSA. Ensure the contractual commitment was met and the safeguarded Medicare Trust Fund dollars with extensive knowledge of Medicare principles, law, and regulations. **Wellpoint/National Government Services LLC (1997-2008)** • Senior Auditor responsible for review of all work papers of auditors for correctness, control and adherence to accounting principles, auditing standards and current Medicare guidelines. Experienced in the most complex audit work in connection with auditing the cost reports and financial records of Medicaid/Medicare Providers. **Wellpoint/National Government Services LLC (1997-2008)** • Medicare Auditor responsible for review of all work papers of auditors for correctness, control and adherence to accounting principles, auditing standards and current Medicare guidelines. Experienced in the most complex audit work in connection with auditing the cost reports and financial records of Medicaid/Medicare Providers. **Pillar West Entertainment (1998-present)** • Responsible for monthly, weekly and daily cash flow projections, accounts payable, accounts receivable, and corporate budgets. Handled payroll, payroll taxes and 941 tax returns. Reported to the president.
Honors and Awards	• Alpha Gamma Sigma Scholastic Honor Society – Life Member • National Government Services' Outstanding Performance Award: 1999, 2000, 2002, 2005 and 2006
Positions Held at Clifton Gunderson	Manager, 2009-present

KRISTIE L. MASILEK
Manager

Education

Bachelor of arts degree with a major in accounting, College of Notre Dame of Maryland, 1996

Years of Experience

12 years

Areas of Specialization

- Health care consulting with an emphasis on fraud investigation and litigation support
- Health care auditing and accounting with an emphasis on Medicaid and Medicare reimbursement

Relevant Experience

State of Maryland Department of Health and Mental Hygiene - Medicaid Program (1996-2005)

- Performed cost report desk reviews and auditing of costs for providers including federally qualified health centers, intermediate care facilities for the mentally retarded, psychiatric hospitals, rehabilitation hospitals, and residential treatment centers.
- Reviewed providers for general compliance with program regulations and requirements, for ongoing compliance with internal policies and statutory requirements, to assess the adequacy of internal control measures, and to test the accuracy and completeness of record-keeping and operational functions

Centers for Medicare & Medicaid Services (CMS) (1997-2002)

- Performed general control and substantive testing to determine the validity, completeness, and existence of items reported in contractor financial reports as part of the Centers for Medicare and Medicaid Services' CFO Act audits for fiscal years 1997, 1998, 2000, and 2002.

State of Maryland Department of Health and Mental Hygiene - Medicaid Program (2001-2005)

- Managed and reviewed desk review verifications of Home Health Agencies with Maryland Medicaid utilization.

U.S. Department of Justice - Civil Division (2001-present)

- Perform litigation support services related to health care entities under investigation for presenting false claims to the government
- Perform litigation support services related to contract law in procurement

Maryland Transit Administration Internal Audit (2005 – 2007)

- Perform internal compliance audits in accordance with pertinent laws, regulations, and contract provisions
- Plan, coordinate, supervise, and evaluate the work of Senior Auditors

Montgomery County Government Internal Audit (2005 – 2007)

- Perform review of county contracts to determine compliance with the Wage Requirements of Section 11B33A of the Montgomery County Code.

Maryland Health Care Commission (2008)

- Responsible for completion of verifications of Maryland Trauma Fund Semi-Annual Uncompensated Trauma Services Applications. This includes on-site visits, report preparation, and reviewing completed verifications.

District of Columbia Department of Health Care Finance (2008 – Present)

- Planning, organization, scheduling, supervision, technical consulting, and completion of Medicaid Cost Report Audits of National Rehabilitation Hospital, Specialty Hospital of Washington, and Psychiatric Hospital of Washington.

Professional Affiliations

- Maryland Association of Certified Public Accountants – CPA Candidate Member

Civic and Social Affiliations

- Carroll County Chamber of Commerce 2001 - 2005
- Carroll County Women's Fair Treasurer 2002, 2003
- Carroll County Women's Fair Facilities Co-Chair 2001
- St. Luke's Lutheran Church Volunteer 2005 – Present

Positions Held at Clifton Gunderson

- Associate, 1996 – 1998
- Sr. Associate, 1998 – 2001
- Manager, 2001 – Present

APPENDIX K:
REQUIRED FORMS

MED-96

AGREEMENT ADDENDUM

In the event of conflict between this addendum and the agreement, this addendum shall control:

1. **DISPUTES** - Any references in the agreement to arbitration or to the jurisdiction of any court are hereby deleted. Disputes arising out of the agreement shall be presented to the West Virginia Court of Claims.

2. **HOLD HARMLESS** - Any clause requiring the Agency to indemnify or hold harmless any party is hereby deleted in its entirety.

3. **GOVERNING LAW** - The agreement shall be governed by the laws of the State of West Virginia. This provision replaces any references to any other State's governing law.

4. **TAXES** - Provisions in the agreement requiring the Agency to pay taxes are deleted. As a State entity, the Agency is exempt from Federal, State, and local taxes and will not pay taxes for any Vendor including individuals, nor will the Agency file any tax returns or reports on behalf of Vendor or any other party.

5. **PAYMENT** - Any references to prepayment are deleted. Payment will be in arrears.

6. **INTEREST** - Should the agreement include a provision for interest on late payments, the Agency agrees to pay the maximum legal rate under West Virginia law. All other references to interest or late charges are deleted.

7. **RECOUPMENT** - Any language in the agreement waiving the Agency's right to set-off, counterclaim, recoupment, or other defense is hereby deleted.

8. **FISCAL YEAR FUNDING** - Service performed under the agreement may be continued in succeeding fiscal years for the term of the agreement, contingent upon funds being appropriated by the Legislature or otherwise being available for this service. In the event funds are not appropriated or otherwise available for this service, the agreement shall terminate without penalty on June 30. After that date, the agreement becomes of no effect and is null and void. However, the Agency agrees to use its best efforts to have the amounts contemplated under the agreement included in its budget. Non-appropriation or non-funding shall not be considered an event of default.

9. **STATUTE OF LIMITATION** - Any clauses limiting the time in which the Agency may bring suit against the Vendor, lessor, individual, or any other party are deleted.

10. **SIMILAR SERVICES** - Any provisions limiting the Agency's right to obtain similar services or equipment in the event of default or non-funding during the term of the agreement are hereby deleted.

11. **ATTORNEY FEES** - The Agency recognizes an obligation to pay attorney's fees or costs only when assessed by a court of competent jurisdiction. Any other provision is invalid and considered null and void.

12. **ASSIGNMENT** - Notwithstanding any clause to the contrary, the Agency reserves the right to assign the agreement to another State of West Virginia agency, board or commission upon thirty (30) days written notice to the Vendor and Vendor shall obtain the written consent of Agency prior to assigning the agreement.

13. **LIMITATION OF LIABILITY** - The Agency, as a State entity, cannot agree to assume the potential liability of a Vendor. Accordingly, any provision limiting the Vendor's liability for direct damages to a certain dollar amount or to the amount of the agreement is hereby deleted. Limitations on special, incidental or consequential damages are acceptable. In addition, any limitation is null and void to the extent that it precludes any action for injury to persons or for damages to personal property.

14. **RIGHT TO TERMINATE** - Agency shall have the right to terminate the agreement upon thirty (30) days written notice to Vendor. Agency agrees to pay Vendor for services rendered or goods received prior to the effective date of termination.

15. **TERMINATION CHARGES** - Any provision requiring the Agency to pay a fixed amount or liquidated damages upon termination of the agreement is hereby deleted. The Agency may only agree to reimburse a Vendor for actual costs incurred or losses sustained during the current fiscal year due to wrongful termination by the Agency prior to the end of any current agreement term.

16. **RENEWAL** - Any reference to automatic renewal is hereby deleted. The agreement may be renewed only upon mutual written agreement of the parties.

17. **INSURANCE** - Any provision requiring the Agency to insure equipment or property of any kind and name the Vendor as beneficiary or as an additional insured is hereby deleted.

18. **RIGHT TO NOTICE** - Any provision for repossession of equipment without notice is hereby deleted. However, the Agency does recognize a right of repossession with notice.

19. **ACCELERATION** - Any reference to acceleration of payments in the event of default or non-funding is hereby deleted.

20. **CONFIDENTIALITY:** - Any provision regarding confidentiality of the terms and conditions of the agreement is hereby deleted. State contracts are public records under the West Virginia Freedom of Information Act.

21. **AMENDMENTS** - All amendments, modifications, alterations or changes to the agreement shall be in writing and signed by both parties. No amendment, modification, alteration or change may be made to this addendum without the express written approval of the Purchasing Division and the Attorney General.

ACCEPTED BY DHHR OFFICE OF PURCHASING:

Spending Unit: _____

Signed: _____

Title: _____

Date: _____

VENDOR

Company Name: Clifton Gunderson LLP

Signed: Mark K. Ute

Title: Partner

Date: May 24, 2010

RFQ No. MED10002

BUREAU FOR MEDICAL SERVICES

MED PURCHASING AFFIDAVIT

West Virginia Code §5A-3-10a states: No contract or renewal of any contract may be awarded by the state or any of its political subdivisions to any vendor or prospective vendor when the vendor or prospective vendor or a related party to the vendor or prospective vendor is a debtor and the debt owned is an amount greater than one thousand dollars in the aggregate

DEFINITIONS:
"Debt" means any assessment, premium, penalty, fine, tax or other amount of money owed to the state or any of its political subdivisions because of a judgment, fine, permit violation, license assessment, defaulted workers' compensation premium, penalty or other assessment presently delinquent or due and required to be paid to the state or any of its political subdivisions, including any interest or additional penalties accrued thereon.

"Debtor" means any individual, corporation, partnership, association, Limited Liability Company or any other form or business association owing a debt to the state or any of its political subdivisions. "Political subdivision" means any county commission; municipality; county board of education; any instrumentality established by a county or municipality; any separate corporation or instrumentality established by one or more counties or municipalities, as permitted by law; or any public body charged by law with the performance of a government function or whose jurisdiction is coextensive with one or more counties or municipalities. "Related party" means a party, whether an individual, corporation, partnership, association, limited liability company or any other form or business association or other entity whatsoever, related to any vendor by blood, marriage, ownership or contract through which the party has a relationship of ownership or other interest with the vendor so that the party will actually or by effect receive or control a portion of the benefit, profit or other consideration from performance of a vendor contract with the party receiving an amount that meets or exceed five percent of the total contract amount.

EXCEPTION: The prohibition of this section does not apply where a vendor has contested any tax administered pursuant to chapter eleven of this code, workers' compensation premium, permit fee or environmental fee or assessment and the matter has not become final or where the vendor has entered into a payment plan or agreement and the vendor is not in default of any of the provisions of such plan or agreement.

Under penalty of law for false swearing ***(West Virginia Code*** §61-5-3), it is hereby certified that the vendor affirms and acknowledges the information in this affidavit and is in compliance with the requirements as stated.

WITNESS THE FOLLOWING SIGNATURE

Vendor's Name: Clifton Gunderson LLP

Authorized Signature: [signature] Date: May 24, 2010

State of Maryland

County of Baltimore, to-wit:

Taken, subscribed, and sworn to before me this 24th day of May, 2010.

My Commission expires February 1, 2011.

AFFIX SEAL HERE NOTORY PUBLIC [signature]

Purchasing Affidavit (Revised 12/15/09)

Request for Quotation

State of West Virginia
Department of Health & Human Resources
Office of Purchasing
One Davis Square, Suite 100
Charleston, WV 25301

RFQ NUMBER	PAGE
MED10002	1

ADDRESS CORRESPONDENCE TO ATTENTION OF
BRYAN ROSEN
304-558-0953

VENDOR	SHIP TO
Clifton Gunderson LLP 9515 Deereco Road, Suite 500 Timonium, MD 21093	BUREAU FOR MEDICAL SERVICES 350 CAPITOL STREET, ROOM 251 CHARLESTON, WV 25301-3706

DATE PRINTED	TERMS OF SALE	SHIP VIA	F.O.B.	FUND

BID OPENING DATE: 5/25/2010 BID OPENING TIME: 1:30 PM

LINE	QUANTITY	UOP	CAT.NO.	ITEM NUMBER	UNIT PRICE	AMOUNT

ADDENDUM NO. 1

1. QUESTIONS AND ANSWERS ARE ATTACHED.
2. ADDENDUM ACKNOWLEDGEMENT IS ATTACHED. THIS DOCUMENT SHOULD BE SIGNED AND RETURNED WITH YOUR BID. FAILURE TO SIGN AND RETURN MAY RESULT IN DISQUALIFICATION OF YOUR PROPOSAL.

REQUISITION NO.: MED10002

ADDENDUM ACKNOWLEDGEMENT

I HEREBY ACKNOWLEDGE RECEIPT OF THE FOLLOWING CHECKED ADDENDUM(S) AND HAVE MADE THE NECESSARY REVISIONS TO MY PROPOSAL, PLANS AND/OR SPECIFICATION, ETC.

ADDENDUM NO.'S"

NO. 1 X
NO. 2 _____
NO. 3 _____
NO. 4 _____
NO. 5 _____

I UNDERSTAND THAT FAILURE TO CONFIRM THE RECEIPT OF THE ADDENDUM(S) MAY BE CAUSE FOR REJECTION OF PROPOSAL.

SEE REVERSE FOR TERMS AND CONDITIONS

SIGNATURE	TELEPHONE	DATE
Mark K Nelson	410-453-0900	5/24/10

TITLE	FEIN	ADDRESS CHANGES TO BE NOTED ABOVE
Partner	37-0802863	

WHEN RESPONDING TO RFP, INSERT NAME AND ADDRESS IN SPACE ABOVE LABELED "VENDOR"

Request for Quotation

State of West Virginia
Department of Health & Human Resources
Office of Purchasing
One Davis Square, Suite 100
Charleston, WV 25301

RFQ NUMBER	PAGE
MED10002	2

ADDRESS CORRESPONDENCE TO ATTENTION OF
BRYAN ROSEN
304-558-0953

VENDOR	SHIP TO
Clifton Gunderson LLP 9515 Deereco Road, Suite 500 Timonium, MD 21093	BUREAU FOR MEDICAL SERVICES 350 CAPITOL STREET, ROOM 251 CHARLESTON, WV 25301-3706

DATE PRINTED	TERMS OF SALE	SHIP VIA	F.O.B.	FUND

BID OPENING DATE: 5/25/2010 BID OPENING TIME: 1:30 PM

LINE	QUANTITY	UOP	CAT.NO.	ITEM NUMBER	UNIT PRICE	AMOUNT

VENDOR MUST CLEARLY UNDERSTAND THAT ANY VERBAL REPRESENTATION MADE OR ASSUMED TO BE MADE DURING ANY ORAL DISCUSSION HELD BETWEEN VENDOR'S REPRESENTATIVES AND ANY STATE PERSONNEL IS NOT BINDING. ONLY THE INFORMATION ISSUED IN WRITING AND ADDED TO THE SPECIFICATIONS BY AN OFFICIAL ADDENDUM IS BINDING.

Mark K. Hilton

SIGNATURE

Clifton Gunderson LLP

COMPANY

5/15/10

DATE

END OF ADDENDUM NO. 1

SEE REVERSE FOR TERMS AND CONDITIONS

SIGNATURE	TELEPHONE	DATE
Mark K Hilton	410-453-0900	5/24/10

TITLE	FEIN	ADDRESS CHANGES TO BE NOTED ABOVE
Partner	37-0802863	

WHEN RESPONDING TO RFP, INSERT NAME AND ADDRESS IN SAPCE ABOVE LABELED "VENDOR"