maryland
health services
cost review commission

To: Chief Financial Officers

From: William Hoff, Deputy Director, Audit & Integrity

Date: January 8, 2026

Re: Special Audit Procedures to be performed by the Independent CPAs for all Maryland Hospitals - CY December 2025

This memo outlines the Special Audit Procedures to be performed by independent Certified Public Accountants (CPAs) for all Maryland hospitals for the fiscal year ending December 2025.

The Special Audit Procedure Reports are due 140 days from the close of the fiscal year. For hospitals with a December 31 fiscal year end, this deadline is May 20, 2026.

Please be advised that, pursuant to COMAR 10.37.01.03R, any required report submitted to the Commission that is substantially incomplete or inaccurate may not be considered timely filed. Furthermore, under this regulation, any hospital failing to file a report due under HSCRC law or regulation is liable for a fine of up to $1,000 for each day the filing of the report is delayed.

Departments (Rate Centers) for CY 2025

For Procedure C-1, the three specific departments to be reviewed by outside auditors for acute hospitals are:

- **Respiratory Therapy (RES)**
- **Radiology – Diagnostic (RAD)**
- **CT Scanner (CAT)**

If a hospital does not have one of the selected departments, the alternate department for review is **Labor And Delivery Services (DEL)**. For the three departments reviewed, please submit a

listing of all procedures for which units of service were assigned "By Report." This listing should be provided in the format specified in Attachment C.

Additional Instructions

Alternative Rate Setting

Audit procedures are to be performed on HSCRC-approved Alternative Method of Rate Determination arrangements. These procedures are to be submitted 140 days from the close of the Related Entities' Fiscal Year under separate cover.

Procedure-based or Case-based Bundled Rates Arrangements: Audit procedures for these arrangements have been added as Step I.

Capitation and Global Price Arrangements: Audit procedures for these arrangements are included in Supplement I. These procedures involve visiting the risk-taking hospital-related entity to confirm the accuracy of the information reported in HSCRC-mandated reports.

For Procedure A-4 (Capitation), the three expense centers from Schedule AR1 to be reviewed by auditors are:

- Med/Surg/Ped/Def (line 10)
- Emergency Department (line 21)
- Imaging (line 31)

If one of the selected centers had no activity, the alternative is Pharmacy (line 40).

Please instruct your auditors to contact Steven Crocker at steven.crocker1@maryland.gov to obtain the following:

- Case Mix data (Procedure D)
- Quarterly reports for Hospice samples (Procedure G)
- Quarterly reports for Cosmetic Surgery (Procedure H)

Enclosure(s)

HEALTH SERVICES COST REVIEW COMMISSION

SPECIAL AUDIT PROCEDURES

A. Expenses

1. Review the reconciliation of the base year actual expenses on Schedules UA, C, D, E-1 through E-9, F-1 through F-4, OADP, P2 through P6, PSI and URI through UR25 of the budget submission financial statements.

    - Prepare a summary worksheet, in the format described in Attachment A, disclosing the reconciling items between the Rate Review System and the audited trial balance. This reconciliation worksheet must be included in your report.

2. During cash disbursements and payroll compliance testing, perform attribute statistical sampling (using a 95 percent confidence and 5% maximum error rate) to test departmental classification of expenses. List results of testing, including the number of test items and number of error occurrences.

B. Revenue

1. Review the reconciliation of the base year actual revenue for the year by the department as accumulated in the monthly Experience Report to the year-end trial balance.

    - Verify that only regulated revenue has been reported on the Monthly Experience report.

    - Prepare a summary worksheet in the format described in Attachment B, disclosing the reconciling items between the departmental revenue reported on the monthly submission and the year-end trial balance. This reconciliation worksheet must be included in your report.

    - List the amount and a description of all classifications made in reconciling revenue between the monthly and the year-end trial balance. This is to be included in your report in the journal entry form.

2. Review Schedule RE-R, Statement of Revenues and Expenses - Reconciliation to audited financial statements.

    - Verify that the reconciliation is complete and accurate. Trace the revenue, deductions from revenue and expenses to the general ledger.

    - Determine by inquiry of the appropriate personnel and review of applicable hospital records that the classification of revenue and allocation of expenses are in conformance with HSCRC regulation and policy. Report results of your inquiry in detail.

C. Statistics

1. For three (3) departments (two departments for private psychiatric hospitals) as stipulated by the Executive Director of the Commission.

    - Determine by inquiry of the appropriate clinical and financial personnel and reference to department source data that the department is using the standard unit of measure as prescribed in the Health Services Cost Review Commission's Accounting and Budget Manual. Please review any variances found with hospital staff and note how the hospital is going to fix the variances noted.

    - Utilize a representative sample of the procedures from one month's data. A selection of the high-volume procedures that constitute at least 50 percent of the department's volume is recommended.

        - Trace the number of units reported to the HSCRC on the monthly PS schedule per procedure to the number of units assigned in Appendix D of the manual.

        - Submit a list of discrepancies found.

        - For each of the discrepancies, determine how long the incorrect number of units has been utilized for reporting and billing purposes.

    - Obtain a list from the appropriate clinical and financial personnel of the departments designated for review of the procedures for which the units of service were assigned "By Report." Provide this list to the Commission using Excel format (see Attachment C) with this report. List the "By Report" procedures for the rate centers under review as follows:

        CPT Code Descriptions RVUs Assigned

    - Summarize the actual base year department statistics (inpatient, outpatient and total) by month and reconcile them to the base year units as reported on the hospital's monthly Experience Report and to the total reported on Schedule V3, Line O of the Annual Report. Test a two (2) month's accumulation of these statistics by tracing them to the source document data to the monthly and Annual Reports. Identify the source document.

    - To ensure that patients are charged appropriately and that the HSCRC receives accurate data, hospitals are directed to establish procedures to review their Charge Master on at least an annual basis. Please review these procedures and obtain from the Chief Financial Officer written verification as to when the charge master was last reviewed and whether processes have been established to regularly review the hospital's Chargemaster.

    - Obtain a copy of the Hospital's Chargemaster Review procedures. Include these procedures in your report.

D. Case Mix Data

Acute Hospital- Inpatient

1. The Commission staff will supply the auditor with a sample of HSCRC inpatient hospital case mix data. The sample listings will include the following information for each patient:

    - Patient Medical Record Number
    - Third Party Payor (i.e., Medicare Fee for Service, Medicare Managed Care, Medicaid, Blue Cross and Other)
    - Zip Code
    - Total Patient Charges
    - Daily hospital services and admission services charges
    - Operating room charges
    - Admission from the Emergency Room charges

2. For each patient, the auditor will verify the case mix data back to the hospital's billing records for items:

    - That the major third-party payor classification **agrees with the hospital's billing records.** If errors in payor classification exceed 5 percent of cases, list the number of errors by **payor** category. Please note, report self-pay variances with the Medicaid category. Show percentage of all errors **and** a percentage less errors involving Medicaid admissions.

    - That the zip code agrees with the hospital's billing records. List all zip code errors showing incorrect zip code and correct zip code.

    - That the total patient charges, for regulated services, agree with the hospital's billing records.

    - That the total Daily Hospital services and Admission Services charges agree with the hospital's billing records.

    - That the total Operating Room charges agree with the hospital's billing records.

    - That the Emergency Service charges for each record coded as "Admitted from Emergency Room (ER)" in the case mix data sample **are present and they agree with the hospital billing record.**

    (Differences in dollar amounts in bullets 3 through 6 above, which are less than 1 percent should not be counted as errors.)

3. In its report, the auditor will describe the results of this work, and the data compiled will be summarized as follows:

a.	Hospital Name	Total Charges per HSCRC Case Mix Data Record	Verified Final Charges	Differences (Over/Under)	Percentage Variances	
b.	Hospital Name	Case Mix Sample Size	Number of Variances in Charge Reported	Error Rate	Number of Variance in Payor Sources	Error Rate
c.	Hospital Name	Case Mix Sample Size	Variance in Daily Service & Admission Charges	Error Rate	Number of Variances in OR Room Charges	Error Rate
d.	Hospital Name	Number of Cases Coded as Admitted from ER	Number of Cases Coded as Admitted from the ER **without** ER Charges	Error Rate		

Private Psychiatric Hospitals

1. The Commission staff will supply the auditor with a sample of HSCRC inpatient psychiatric hospital case mix data. The sample listing will include the following information for each patient:

    - Patient Medical Record Number
    - Third Party Payer (i.e., Medicare Fee for Service, Medicare Managed Care, Medicaid, Blue Cross and Other)
    - Zip Code
    - Total Patient Charges
    - Daily hospital services and admission services charges
    - Therapy charges

2. For each patient, the auditor will verify case mix data back to the hospital's billing records for items:

    - That the major third-party payor classification agrees with the hospital's billing records. If errors in payor classification exceed 5 percent of cases, list the number of errors by payor category. Please note, report self-pay variances with the Medicaid category. Show percentage of all errors **and** a percentage less errors involving Medicaid admissions.

    - That the zip code agrees with the Hospital's billing records. List all zip code errors showing incorrect zip code and correct zip code.

    - That the total patient charges, for regulated services, agree with the hospital’s billing records.

    - That the total Daily Hospital services and Admission Services charges agree with the hospital's billing records.

    - That the therapy charges agree with the hospital's billing records.

    (Differences in dollar amounts in bullets 3 through 5 above, which are less than 1 percent should not be counted as errors.)

3. In its report the auditor will describe the results of this work, and the data compiled will be summarized in the following manner:

a.	Hospital Name	Total Charges per HSCRC Case Mix Data Record	Verified Final Charges	Differences (Over/Under)	Percentage Variances	
b.	Hospital Name	Case Mix Sample Size	Number of Variances in Charge Reported	Error Rate	Number of Variance in Payor Sources	Error Rate
c.	Hospital Name	Case Mix Sample Size	Variance in Daily Service & Admission Charges	Error Rate	Number of Variances in OR Room Charges	Error Rate
d.	Hospital Name	Number of Cases Coded as Admitted from ER	Number of Cases Coded as Admitted from the ER **without** ER Charges	Error Rate		

Ambulatory Care

1. The Commission staff will supply the auditor with a sample of HSCRC outpatient hospital case mix data. The sample listing will include the following information for each patient:
    - Patient Medical Record Number
    - Third Party Payer (i.e., Medicare Fee for Service, Medicare Managed Care, Medicaid, Blue Cross and Other)
    - Zip Code
    - Operating Room and Same Day Surgery Charges
    - Clinic and Emergency Department Charges
    - Medical Surgical Supplies Charges
    - Drugs Charges
    - Other Charges

2. For each patient, the auditor will verify the case mix data back to the hospital's billing records for items:

    - That the major third-party payor classification agrees with the hospital's billing records. If errors in payor classification exceed 5 percent of cases, list the number of errors by payor category. Please note, report self-pay variances with the Medicaid category. Show percentage of all errors **and** a percentage less errors involving Medicaid admissions.

    - That the zip code on the Commission's case mix records agrees with the Hospital's billing records. List all zip code errors showing incorrect zip code and correct zip code.

    - That the total patient charges, for regulated services, agree with the hospital’s billing records.

    - That the total Operating Room and Same Day Surgery charges agree with the hospital's billing records.

    - That the total Clinic and Emergency Department Charges agree with the hospital’s billing records.

    - That the total Medical Surgical Supplies charges agree with the hospital’s billing

records.

- That the total Drugs charges agree with the hospital's billing records.
- Identify and report the charges in the "Other Charges" category.

  (Differences in dollar amounts in bullets 3 through 8 above, which are less than 1 percent should not be counted as errors.)

3. In its report the auditor will describe the results of this work, and the data compiled will be summarized in the following manner:

a.	Hospital Name	Total Charges per HSCRC Case Mix Data Record	Verified Final Charges	Differences (Over/Under)	Percentage Variances	
b.	Hospital Name	Case Mix Sample Size	Number of Variances in Charge Reported	Error Rate	Number of Variance in Payor Sources	Error Rate
c.	Hospital Name	Case Mix Sample Size	Variance in O/R and SDS Charges	Error Rate	Number of Variances in M/SS Charges	Error Rate
d.	Hospital Name	Case Mix Sample Size	Number of Variances in CL and ER Charges	Error Rate	Number of Variances in CDS Charges	Error Rate

E. Uncompensated Care and Denials Reconciliation

1. Maryland hospitals report deductions from patient revenue in their required annual filings. The deduction categories include charity care, bad debts, contractual adjustments, denials, and other deductions from revenue. See Attachment D for a copy of the relevant section of the HSCRC Accounting and Budget Manual.

   - Perform an analysis of the bad debt write-off activity of more than $1,000 (but not less than 50 percent of the total dollars written off) for a calendar month of the fiscal year. Determine whether those accounts unpaid by third party payors for medically-unnecessary care are not included. Obtain a letter of representation from the Patient Accounting Manager and Chief Financial Officer that the bad debt expense does not include medically-unnecessary care, denials or other courtesy discounts provided to police, fire, hospital employees, etc.
   - Disclose in your report whether the hospital maintains these denials in a separate account pending final resolution of appeal.

2. For calendar year 2025, provide reconciliation between the amount of uncompensated care per the hospital's trial balance to the supporting documentation.

3. For calendar year 2025, provide reconciliation between the amount of uncompensated care per the hospital's trial balance and that reported on Schedule PDA of the Annual Report of Revenues, Expenses and Volumes.

4. Reconcile the Charity Care amount per the hospital's trial balance to the hospital's supporting documentation. Provide reconciliation between the hospital's trial balance and that reported on

Schedule RE Line G Column 3 of the Annual Report of Revenues, Expenses and Volumes. Note any differences.

5. Reconcile the Provision for Bad Debt amount per the hospital's trial balance to the hospital's supporting documentation. Provide reconciliation between the amount in the hospital's trial balance and the amount reported on Schedule RE line F Column 3 of the Annual Report of Revenue, Expenses and Volumes. Note any differences.

6. For calendar year 2025, provide reconciliations between the number of denials per the hospital's trial balance and that reported on Schedule RE of the Annual Report of Revenue, Expenses and Volume and the quarterly Denials Report.
   The reconciliations shall be provided in the following format:

Trial Balance	
Bad Debt	$
Charity Care	$
Uncompensated Care	$_____
Trial Balance	
Bad Debt Write-offs	$
Charity Write-offs	$
Change in Balance Sheet Reserve	$
Bad Debt Recoveries	$
Other ***(Explain in detail)***	$
Uncompensated Care per Trial Balance	$_____
Annual Report of Revenues, Expenses and Volumes	
Uncompensated Care - Schedule PDA	$
Unregulated Charity & Bad Debts	$
Uncompensated Care Fund ***(Note: Hospitals with unregulated services are expected to have unregulated bad debt.)***	$
Other ***(Explain in detail)***	$
Uncompensated Care per Annual Report	$_____
Denials	
Denials per the Trial Balance	$_____
Less Unregulated Denials per the Trial Balance	$_____
Schedule RE Line H2 Column 3, Annual Report of Revenues, Expenses and Volumes	$_____
Quarterly Denials Report	$_____
Variance ***(Explain in detail)***	$_____

7. Determine by inquiry of the appropriate hospital personnel and report whether bad debt write-offs include denials, collection agency's or attorney's expenses.

F. Financial Assistance and Credit & Collection Policies

Financial Assistance

1. Hospitals are required by regulation (COMAR 10.37.10.26 A-2 (5)) to post notices in conspicuous places throughout the hospital informing patients of their right to apply for financial assistance and who to contact at the hospital for additional information.

    - Determine whether such notices are posted.
    - Describe the content of the notices and list where they are posted in the hospital.
    - Determine by inquiry of the appropriate hospital personnel if patients are informed of the availability of financial assistance in any way other than by the posted notices.

2. Hospitals are also required by regulation (COMAR 10.37.10.26 A-2 (5)) to develop an information sheet that shall be provided to the patient, the patient's family, or the patient's authorized representative before the patient receives scheduled medical services; before discharge, with the hospital bill, on request, and in each written communication to the patient regarding collection of the hospital bill.

    - Determine by inquiry of the appropriate personnel if an information sheet is provided before discharge, with the hospital bill, upon request, and in each written communication to the patient regarding collection of the hospital bill.
    - **Verify that the information sheet is in**
        - **Simplified language**
        - **At least 10-point type**
        - **Available in the language spoken by a limited English proficient population that constitutes 5 percent of the overall population within the city or county in which the hospital is located as measured by the most recent census.**
    - **Verify that the hospital bill includes a reference to the information sheet.**
    - **Verify that the information sheet includes the following items:**
        - Description of the hospital's financial assistance policy.
        - Description of patient's rights and obligations regarding hospital billing and collection;
        - Contact information for the individual or office at the hospital that is available

to assist the patient, **the patient's family**, or the patient representative in understanding the hospital bill, **the patient's rights and obligations with regard to the bill, including with regard to reduced-cost, medically necessary care due to financial hardship,** how to apply for free and reduced cost care **and how to apply for the Maryland Medical Assistance Program and any other programs that may help pay the bill;**

- Contact information for the Maryland Medical Assistance Program.
- Statements that physician charges **for both hospital inpatients and outpatients** are not included in the hospital bill and are billed separately.
- **Informs patients that the hospital is permitted to bill outpatients a "facility fee" for the use of hospital facilities, clinics, supplies, equipment and nonphysician services, in addition to physician fees billed for professional services.**
- **Informs patients of their right to request and receive a written estimate of the total charges for the hospital nonemergency services, procedures, and supplies that reasonably are expected to be provided and billed for by the hospital.**
- **Informs patients or a patient's authorized representative of the right to file a complaint with the Commission or jointly with the Health Education and Advocacy Unity of the MD Attorney General's office for an alleged violation of HG §§19-214.1 and 19-214.2, Annotated Code of Maryland.**
- **Provides the patient with contact information for filing the complaint.**

3. Review the hospital's Financial Assistance Policy to determine whether the Policy includes the minimum criteria for providing free and reduced-cost care to low-income patients who lack health care coverage or to patients whose health insurance does not pay the full cost of the hospital bill, as mandated in COMAR 10.37.10.26A-2(2). Confirm the following language is stated in the hospital's policy:

    - Free medically necessary care to patients with family income at or below 200 percent of the poverty level;
    - Reduced cost medically necessary care to low-income patients with family income between 200 and 300 percent of the federal poverty level, in accordance with the mission and service area of the hospital;
    - A maximum patient payment for reduced-cost care not to exceed the charges minus the hospital mark-up, no interest or fees may be assessed;
    - A payment plan is available to **patients with family income between 200 and 500 percent of the federal poverty level who request assistance, irrespective of insurance**

status; and

- A mechanism for a patient to request the hospital to reconsider the denial of free or reduced care, **including the address, phone number, facsimile number, email address, mailing address and website of the Health Education and Advocacy Unit.**

4. Select a representative sample of 50 cases, from the period October 1st through December 31, 2025, of patients who have applied for financial assistance. The sample shall include both patients approved for financial assistance and those who were denied.

    - Determine whether the Financial Assistance Policy was followed:

    - Provide the number of cases and percentage of sample in which the policy was followed 100%.

    - Provide the number and percentage of cases in which the policy was not followed.

    - When the policy was not followed, provide examples of deviation from the policy and the frequency of each exception in the sample tested.

5. Select a representative sample of 25 cases with charges greater than $1,000 that were written off to bad debts and turned over to a collection agency.

    - Determine whether these patients were screened by either the hospital, or, the collection agency, to determine their eligibility under the Financial Assistance Policy, prior to any collection attempt:

    - Report the number of patients:

        - Screened using documentation provided by the patient.

        - Screened by searching publicly available information.

        - Screened utilizing a combination of documentation provided by the patient and by searching publicly available information.

        - Not screened before an attempt was made by the collection agency to collect the outstanding debt.

    - Determine by inquiry of the appropriate personnel and report the reason for failure to screen for each patient not screened.
      Screening requires that the hospital take the following actions prior to beginning collection efforts. HSCRC understands that some outstanding accounts for patients who have not completed a financial assistance application, or whose eligibility for financial assistance cannot be determined, may be written off to bad debt and sent to a collection agency. The hospital is responsible for ensuring that the collection agency conducts a search of publicly available records before collection activities begins. To document that

this search has been conducted appropriately, the hospital must show that it or its agent acting on behalf of the hospital has performed the following steps:

Step 1: Attempted to initiate in-person contact with the patient informing him/her of the availability of financial assistance and inquired about possible need. (Note: sending the information sheet with the hospital bill does not satisfy this step)

Steo 2: Compared the patient's income to the federal poverty level by:

- Searching any publicly available financial information, e.g., credit score, to ascertain whether the patient may be presumed to be eligible for financial assistance, and/or
- Verifying insurance status, income, etc. through documentation provided by the patient.

Step 3: Determine whether the patient is an active participant in a means-tested social services program that may qualify him/her for financial assistance (see item #7 below) by:

- Searching any publicly available financial information, e.g., credit score, to ascertain whether the patient may be presumed to be eligible for financial assistance, and/or
- Verifying insurance status, income, etc. through documentation provided by the patient.

Step 4: Determine whether the patient is eligible for Medicaid.

6. Hospitals are required by regulation (COMAR 10.37.10.26 A-2 (2)) to provide eligibility for free care to patients that receive benefits under the following programs and are not eligible for the Maryland Medical Assistance Program or Maryland Children's Health Program:

    i. Households with children in the free or reduced cost meal program;
    ii. Supplemental Nutrition Assistance Program (SNAP);
    iii. Maryland Low-income-household energy assistance program (MEAP);
    iv. Women, Infants and Children (WIC).

- Ascertain, by inquiry of the appropriate personnel, and report the process through which the hospital determines if the patient is eligible for free care by meeting any of the criteria in #6(i) through #6(iv) above.
- Report the number of patients who qualified for free care by being eligible for benefits in one of these programs.

Credit and Collection Policy

7. Review the hospital's Credit & Collection Policy to determine if the policy meets the requirements in Health General 19-214.2, Maryland Code, and COMAR 10.37.10.26 A-1.

    - Select a representative sample of 50 cases that have required collection effort within the last twelve months. The sample shall include both inpatient and outpatient cases and shall include cases from insured as well as self-pay patients, as well as patients who have been granted partial financial assistance, if applicable.

    - Determine whether the Credit and Collection Policy was followed:

        - Provide the number of cases and percentage of sample in which the policy was followed 100%

        - Provide the number and percentages of cases in which the policy was not followed.

        - When the policy was not followed, provide examples of deviation from the policy and the frequency of each exception in the sample tested.

Recoveries

8. Select a representative sample of 25 cases, from the period April 1st through June 30, 2025, where recoveries of bad debts were made (add cases from prior recent calendar quarters to reach sample size if necessary).

    - Determine if the hospital's uncompensated care for the year of recovery was reduced by the full amounts recovered and that the recovered amount is not reduced by collection agency fees or other collection expenses.

    - Provide the number of cases and the percentage of the sample in which any part of the recovery was applied to the hospital's bad debt expense or reserve.

    - Of the cases where all or part of the recovery was applied to the hospital's bad debt expense or reserve:

        - Provide the number of cases and percentages of the sample in which the gross amount of the bill recovered was applied to the hospital's bad debt expense or reserve; and

        - Provide the number of cases and percentages of the sample in which the gross amount of the bill recovered was not applied to the hospital's bad debt expense or reserve.

G. Hospice General Inpatient Services

In March 2001, the Commission approved a Demonstration Project for the provision of general inpatient care to hospice patients to registered Medicare Hospice patients at Maryland hospitals. The project was approved with the following provisions:

- Hospices must bill HSCRC approved rates;
- Hospital may agree to accept reimbursement on a per diem amount other than HSCRC approved rates;
- The balance remaining of the hospital bill for each individual hospice patient payment of the agreed amount must be written off by the hospital as a voluntary contractual allowance. These voluntary contractual allowances may not be included as uncompensated care in reports submitted to the HSCRC.

1. Determine by inquiry of appropriate hospital personnel and report whether the hospital has signed an agreement to provide inpatient services to hospice patients. Provide a list of hospices involved in the agreement.

2. Obtain the following data from the hospital records and reconcile the data to the hospital's quarterly reports:
   - the number of hospice patients admitted in CY 2025;
   - the total of HSCRC approved charges billed for inpatient services provided to hospice patients;
   - the total reimbursement received on behalf of hospice patients;
   - the amount of revenue written off associated with the difference between HSCRC charges billed for inpatient services provided to hospice patients and the total reimbursement received on behalf of hospice patients;
   - the account to which the revenue, described in bullet 4 above, was written off.

H. Outpatient Plastic/Cosmetic Surgery

1. Reconcile Columns 2-5 of the hospital's Outpatient Plastic/Cosmetic Surgery Pricing worksheet to their Plastic/Cosmetic Surgery quarterly reports.

2. Ensure that the total difference in Col. 6 per the Outpatient Plastic/Cosmetic Pricing worksheet agrees with the hospital's Cosmetic Surgery contractual allowance account.

I. Audit for Trauma Costs

Hospitals with designated trauma centers incur incremental trauma costs to meet the Maryland Institute for Emergency Services System (MIEMMS) regulatory requirements. Such incremental costs are the costs associated with operating a hospital with a designated trauma center that are over and above the costs normally associated with hospitals that do not have a designated trauma center. These incremental costs consist of the costs associated with a Trauma Director, Trauma Department, Trauma Protocol, Specialized Trauma Staff, Education and Training and Special Equipment included in the costs of the Emergency on Schedule D-18.

1. For each of the following schedules trace the amounts to the hospital source documents. Review the method used to allocate costs between trauma requirements and normal emergency room operations. Include the method of allocation in your report.

    - Schedule MTC – A Trauma Director
    - Schedule MTC – B Trauma Department
    - Schedule MTC – C Trauma Protocol
    - Schedule MTC – D Specialized Trauma Staff
    - Schedule MTC – E Education and Training Costs
    - Schedule MTC – F Specialized Equipment
    - Schedule MTC – Incremental MIEMMS Requirements for Trauma Hospitals

    Hospitals with designated trauma centers incur trauma physicians to "standby." Trauma physicians' standby cost is defined as the costs generated because of the necessity to have the physical presence of a trauma physician, under a formal arrangement, to render services to trauma patients. These physicians must be on the hospital premises in reasonable proximity to the Emergency Department or trauma center and may not be "on-call."

2. Trace the reported amounts on the following schedules to the hospital source document.

    - Schedule SBC I standby Costs Trauma Physicians - Hourly or Salary Based Arrangement.
    - Schedule SBC II Standby Costs Trauma Physicians - Minimum Guaranteed Arrangements.

J. Community Benefit Report

1. Reconcile the Charity Care amount per the FY 2024 Community Benefit Report (line H) to the RE Schedule per the CY 2024 Annual Filing. Note any differences.

K. Supplemental Schedule UR6-A Physician Part B Service

1. Reconcile the information provided on Supplemental Schedule UR6-A to the information provided on Schedule UR6 submitted by the hospital.

L. Comparison of Supplemental Schedules to Audited Financial Statements

1. Identify and report those costs shared and/or allocated between the parent entity (and/or other system related entities) and the subject hospital.

    - Such reporting to include the identity of the related entity, cost center of the related entity, a description of the nature of cost shared or allocated, the direction of the asset or service cost shared (provided to/by the subject hospital), and the method/basis employed for any such allocation, such shared or allocated cost include but are not limited to:

staffing resources and/or employee benefits; purchased services and/or supplies; rentals for space and/or equipment; loans and/or grants; insurance; management oversight; internal finance, accounting, and/or billing services; information technology (hardware, software and/or design and operations); professional service fees (legal, consulting, CPAs); physicians' services and/or practice subsidies; and equity investments.

- Such reporting should relate the subject hospital and the system related entities as presented in the supplementary schedules appended to the audited financial statements.

- This report should take the form of a table (see the Shared Services and Allocations Schedule) listing all material allocations (and/or cumulative intercompany transactions), the amounts allocated to the subject hospital, and the basis for the allocation. The material allocation threshold is $500,000.

2. Determine that the allocation methodologies were applied consistently and accurately.

M. Report

1. Prepare a report in accordance with the Statement on Auditing Standards No. 75 (SAS 75), as amended, to be submitted to the hospital (with a copy mailed by the auditing firm to the Health Services Cost Review Commission) summarizing the procedures performed and the results. Prepare the report in accordance with the following specific report format instructions.

    - After the "Report of Independent Public Accountants," each step will be detailed in the following manner:

        - Reference specific audit step

        - State the procedures performed to accomplish each audit step.

        - Summarize your audit findings for each step.

2. This report is to be filed with the Commission 140 days after the end of the hospital's fiscal year.

ATTACHMENT A

Expense Reconciliation

We compared the reconciliation of the base-year actual expense on Schedules UA, OADP, P21, P3H, PSI, C, D, El through E9, Fl through F4 and UR-l through UR-7 of the annual report to the Commission with the year-end trial balance used to prepare the audited financial statements.

The following is a reconciliation between the annual report and December 31, 2025, audit financial statements:

Balance per Annual Report:

Description	Source Schedule	Amounts (in thousands)
Cafeteria, Parking, Data	OADP, Line C1, Col.4	
Unassigned Expenses	UA, Line A, Col. 10	
Medical Staff Services	P2I, Line A, Col. 3	
Physician Support Staff	P3H, Line Col.7	
Resident & Intern Services – Eligible	P4I, Line D, Col. 7	
General Services Centers	C, Lines C1-C4, Col. 7	
Patient Care Centers	D, Lines D1-D81, Col. 5	
Auxiliary Enterprises	E1-E9, Line B, Col. 3	
Other Institutional Programs	F1-F7, Line B, Col. 3	
Unregulated Services	UR1-UR10	
*Reconciliation Amount		
HSCRC TOTAL OPERATING EXPENSES		

Balance per Audited Financial Statements:

Description	Amounts (in thousands)
Salaries and Wages	
Employee Benefits	
Supplies	
Services and Other	
Depreciation and Amortization	
Interest	
TOTAL OPERATING EXPENSES PER AUDITED FINANCIAL STATEMENTS	

ATTACHMENT B

Revenue Reconciliation

We compared the reconciliation of the base year actual revenue for the year by department as reported on monthly reporting schedules RSA, RSB, and RSC to the hospitals year-end trial balance.

The following is a reconciliation between the departmental revenue reported on the monthly submissions and the year-end trial balance.

Reconciliation of Operating Revenues
Per Schedule RS
For the Base Year Ended
June 30, 2025

	Revenue Per Schedule RS	Revenue Per Audited Trail Balance	Variance	Explanation
Medical/Surgical				
Pediatrics				
Obstetrics				
ICU				
Nursery				
Emergency Room				
Part A and B				
Admissions				
Labor and Delivery				
Operating Room				
Anesthesiology				
Laboratory				
Blood Bank				
EKG				
Radiology Diagnostic				
Nuclear Medicine				
Cat Scanner				
Respiratory Therapy				
Physical Therapy				
Medical/Surgical Supplies				
Drugs				
Psychiatrics				
Clinical Services				
Ambulatory Surgery				

Explanation of Reclassifications:

ATTACHMENT C

Hospital Name:
FYE:
Special Audit Procedure C Statistics - By Report
Rate Center:

CPT Code	Description	RVU's Assigned

ATTACHMENT D

HEALTH SERVICES COST REVIEW COMMISION
ALTERNATIVE METHOD OF RATE DETERMINATION ARRANGEMENTS
SPECIAL AUDIT PROCEDURES

As a result of the adoption and implementation of the Commission's Alternative Method of Rate Determination Policy, audit procedures must be performed by an independent CPA to ensure that the information provided concerning approved alternative rate setting arrangements is accurate. This will require the independent CPA to visit the offices and review the appropriate documents and records of the risk-taking entity. These audit procedures will be due in a report under separate cover 140 days from the close of the calendar year of the risk-taking related entity.

A. Capitation- Schedules AR-1 and AR-2

1. **Member Months:** For each contract trace to source document the number of member months for the fiscal year online A, Schedule AR-1.

2. **Revenue:** For each contract, reconcile the actual revenue for the year as reported on Schedule AR-1 by component to the trial balance and source documents.

    - Prepare a summary worksheet, reconciling the revenue reported on the quarterly AR-1 schedules and the year-end trial balance. This reconciliation worksheet must be included in your report.

    - List the amount and a description of all reclassifications made in reconciling revenue between the quarterly reports and the year-end trial balance. This is to be included in your report in the journal entry form. Prepare a reconciliation between the total amounts above and the amounts in the audited financial statement. Include this reconciliation in your report.

3. **Expenses:** For each contract, reconcile the actual expense as reported on quarterly and annual Schedules AR-1 to the trial balance.

    - Prepare a summary worksheet, disclosing the reconciling items between the AR-1 schedule and the trial balance. This reconciliation worksheet must be included in your report.

4. **Expenses and Statistics:** For each contract and for each of the three expense centers as stipulated by the Executive Director of the Commission:

    - Determine by inquiry of appropriate personnel and reference to source data whether the standard unit of measure as prescribed in the Health Services Cost Review Commission's Accounting and Budget Manual is being used and reported on Schedule AR-2.

- Summarize base-year actual expenses and statistics by quarter and reconcile to the actual statistics and expenses reported on Schedules AR-1 and AR-2. Test one quarter's accumulation of these expenses and statistics by tracing source data. Include in your report the reconciliation of the source document to the quarterly and annual reports. Determine that expenses are reported in the appropriate category, e.g., capitated, fee for service, related entity, out-of-network, etc., identify the sources documents.

5. **Overhead Allocation:**

    - Determine by review and by inquiry of the appropriate personnel the method used to allocate overhead expenses to each contract.

    - Disclose the methodology and verify that the methodology was properly utilized.

6. **Stop-Loss**

    - Ascertain by review and inquiry of the appropriate personnel and disclose the cost, terms, (e.g., when stop loss kicks in) and coverage of all reissuances, stop-loss contracts and/or other arrangements to limit risk associated with each contract.

B. Global Price - Schedule AR-3

1. **Revenue:** For each contract reconcile the global payments as reported on Schedule AR-3 by DRG to the trial balance and source documents.

    - Prepare a summary worksheet reconciling the revenue reported on the quarterly AR-3 schedules and the year-end trial balance. This reconciliation must be included in your report.

2. **Number of Cases, Patient Days and Hospital Charges:** For each contract; reconcile the number of cases, patient days and hospital charges by DRG as reported on AR-3 schedule to the appropriate source documents.

    - Test one quarter's hospital charges as reported on AR-3 schedule for 2 DRG's by examining the hospital bills of individual cases.