

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

Introduction

This cost limit protocol will meet the required protocol specifications pursuant to Massachusetts 1115 Demonstration Special Terms and Conditions (STC) 50(f). According to this protocol:

- 1) The cost limit must be calculated on a provider-specific basis.
- 2) Only the providers receiving SNCP payments for uncompensated care pursuant to STC 49(c) will be subject to the protocol.
  - a. All Medicaid Fee-for-Service payments for services and managed care payments, including any supplemental or enhanced Medicaid payments made under the State plan<sup>1</sup>, SNCP payments subject to the Provider Cap pursuant to STC 50(c), and any other revenue received by the providers by or on behalf of Medicaid-eligible individuals or uninsured patients are offset against the eligible cost. Payments that are not service payments for the provision of medical care are not offset against the eligible cost. Since the following payments are not payments for the provision of medical care, they are not offset against the eligible cost: SNCP grants and performance-based, incentive, and shared savings payments. These include performance- and incentive-based payments and grants and awards both currently in existence and those that may be implemented during future demonstration renewal periods, such as those listed below.
  - b. Performance- and incentive-based payments, including but not limited to:
    - i. Pay-for-performance payments made under the Medicaid state plan;
    - ii. Quality incentive payments associated with an alternative payment arrangement authorized under the Medicaid state plan or the section 1115 demonstration;
    - iii. Delivery System Transformation Initiative payments made under the 1115 demonstration;
    - iv. Patient Centered Medical Home Initiative payments, including care management and coordination payments, made under the 1115 demonstration;
    - v. Shared savings and other risk-based payments under an alternative payment arrangement (e.g., Primary Care Payment Reform, subject to CMS approval), authorized under the Medicaid state plan or the section 1115 demonstration;

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<sup>1</sup> State Plan supplemental payments include, but may not be limited to, Essential MassHealth Hospital Payments, Freestanding Pediatric Acute Hospital Payments, Acute Hospitals with High Medicaid Discharges Payments, and Infant and Pediatric Outlier Payment Adjustments. Safety Net Care Pool supplemental payments under the 1115 demonstration include Public Service Hospital Payments.

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

- vi. Medicaid EHR incentive payments, including eligible provider and hospital Electronic Health Record (EHR) incentive payments, made in accordance with the CMS-approved state Medicaid Plan and CMS regulations.
  
- c. Grants and awards:
  - i. Infrastructure and Capacity Building grants and any other grants or awards awarded by the Commonwealth of Massachusetts or any of its agencies;
  - ii. Any grants or awards through the CMS Innovation Center or other federal programs;
  - iii. Any grants or awards by a private foundation or other entity.

**Acute Inpatient and Outpatient Hospital Protocol for Medicaid and Uncompensated Care Cost**

**Determination of Allowable Medicaid and Uninsured Costs**

- a. Disproportionate Share Hospital (DSH) Allowable Costs
  - i. Per STC 50(f), the Commonwealth will use the Medicaid DSH statutory, regulatory, and policy definitions of allowable inpatient hospital and outpatient hospital services and allowable Medicaid and uninsured costs in determining hospital-specific cost limits in its cost protocols. To the extent that the determination of uncompensated care costs varies from the Medicaid DSH requirements, the process must be accounted for in this document.
  - ii. Allowable pharmacy costs include the cost of drugs and pharmacy supplies requested by patient care departments and drugs charged to patients. Pharmacy service costs that are not part of an inpatient or outpatient service, such as retail pharmacy costs, are not considered eligible for inclusion in the hospital-specific uncompensated cost limit allowable under DSH. To the extent that the determination of allowable pharmacy costs varies from the Medicaid DSH requirements, the process must be accounted for in this document.
  - iii. Costs included must be for services that meet the federal definition and the approved Massachusetts State plan definition of “hospital services” for medical assistance. “Medical assistance” is defined as the cost of care and services “for individuals, and, with respect to physicians’ or dentists’ services, at the option of the State, to individuals [who are eligible]...” per Section 1905 of the Act.
- b. Medicaid State Plan Allowable Costs
  - i. Massachusetts will use the same definition for all inpatient hospital, outpatient hospital, and physician services, clinic services, non-hospital services, etc. as described in its approved Medicaid State plan,

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

and in accordance with Section 1905 of the Social Security Act and the regulations promulgated thereunder, to define allowable service costs provided by acute inpatient and outpatient hospitals. Massachusetts identifies other service costs, subject to CMS approval, that are not included in the Medicaid state plan definitions to be included as allowable uncompensated care costs in this document (see Cost Element table).

1. Inpatient acute hospital services: Medical services provided to a member admitted to an acute inpatient hospital. Such services are as described in Section 1905 of the Social Security Act and the regulations promulgated thereunder.
  2. Outpatient acute hospital services: Outpatient Hospital Services include medical services provided to a member in a hospital outpatient department. Such services include, but are not limited to, emergency services, primary-care services, observation services, ancillary services, and day-surgery services. Outpatient Services include medical services provided to a member in an outpatient setting including but not limited to hospital outpatient departments, hospital-licensed health centers or other hospital satellite clinics, hospital-based physicians' offices, hospital-based nurse practitioners' offices, freestanding ambulatory surgery centers, day treatment centers, or the member's home. Such services are as described in Section 1905 of the Social Security Act and the regulations promulgated thereunder.
- c. 1115 Demonstration Allowable Costs
- i. 1115 Demonstration Expenditures: Costs incurred by acute hospitals for providing Medicaid state plan services to members eligible for Medicaid through the 1115 demonstration (i.e., expansion populations) will be counted as allowable costs. In addition, allowable costs of services that are not authorized under the Medicaid state plan and are provided by acute hospitals under the 1115 demonstration include expenditures related to services provided in the programs below and described in the Cost Element table. All services authorized under the section 1115 demonstration are subject to the requirements and limitations specified in the STCs.
    1. The Commonwealth must not claim costs for the Pediatric Asthma Pilot Program until receiving CMS approval of the Pediatric Asthma Program payment protocol as described in Special Term and Condition 40(h).
    2. Intensive Early Intervention Services for Children with Autism Spectrum Disorder. The Commonwealth must not claim costs for the Intensive Early Intervention Services for Children with Autism Spectrum disorder until CMS approves the Intensive

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

Early Intervention Services for Children with Autism Spectrum Disorder the Pediatric Asthma Pilot Program payment protocol as specified in STC 40(h).

3. Diversionary Behavioral Health Services.
  - d. Medicaid Managed Care Costs: Costs incurred by acute hospitals for providing services to members enrolled in Medicaid managed care organizations including Senior Care Organizations (SCOs) and Integrated Care Organization (ICOs), prepaid inpatient health plans, and any prepaid ambulatory health plans. Eligible costs are determined using the same methodology under this section.
  - e. Other Allowable Costs, Approved 1915(c) Waivers – Allowable costs are defined in the Cost Element table.
  - f. Additional Allowable Costs – Allowable costs are defined in the Cost Element table.

**I. Summary of 2552-10 Cost Report (CMS 2552 cost report)**

Worksheet A: Reclassification and Adjustment of Trial Balance of Expenses  
Worksheet A provides for recording the trial balance of expense accounts from your accounting books and records. It also provides for the necessary reclassifications and adjustments to certain accounts. Not included on Worksheet A are items that conflict with Medicare regulations, manuals, or instructions but which providers may wish to claim and contest.

The trial balance of expenses is broken down into the following categories to facilitate the transfer of costs to the various worksheets:

- 1) General service cost centers
- 2) Inpatient routine service cost centers
- 3) Ancillary service cost centers
- 4) Outpatient service cost centers
- 5) Other reimbursable cost centers
- 6) Special purpose cost centers
- 7) Other special purpose cost centers not previously identified
- 8) Costs applicable to nonreimbursable cost centers to which general service costs apply
- 9) Nonreimbursable cost center to accumulate the cost incurred by you for services related to the physicians' private practice

Worksheet B

Worksheet B allocates overhead (originally identified as general service cost centers) to all other cost centers, including the non-reimbursable costs identified in lines 96 through 100.

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

Cost finding is the process of recasting data derived from the accounts ordinarily kept by the provider to ascertain costs of the various types of services rendered; i.e., the allocation of the expenses of each general service cost center to those cost centers which receive the services. The CMS 2552 approved method of cost finding is recognized and outlined in 42 CFR 413.24 and is based on the accrual basis of accounting except where government institutions operate on a cash basis of accounting.

Worksheet C

Worksheet C computes the ratio of cost to charges (RCC) for inpatient services, ancillary services, outpatient services, and other reimbursable services. The total cost for each cost center is derived from Worksheet B after the overhead allocation, and the total charge for each cost center is determined from the provider's records. This RCC is used on Worksheet D, Worksheet D-3, Worksheet D-4, Worksheet H-3, and Worksheet J-2 to determine the program's share of ancillary service costs in accordance with 42 CFR 413.53. This worksheet is also needed to determine the adjusted total costs used on Worksheet D-1.

Worksheet D

This series of worksheets is where the total costs from Worksheet B are apportioned to different payer programs. Apportionment is the process by which a cost center's total cost is allocated to a specific payer or program or service type. Apportionment is used to arrive at Medicare hospital inpatient routine and ancillary cost and Medicare hospital outpatient cost, etc.

Worksheet D consists of the following five parts:

- 1) Part I: Apportionment of Inpatient Routine Service Capital Costs
- 2) Part II: Apportionment of Inpatient Ancillary Service Capital Costs
- 3) Part III: Apportionment of Inpatient Routine Service Other Pass Through Costs
- 4) Part IV: Apportionment of Inpatient/Outpatient Ancillary Service Other Pass Through Costs
- 5) Part V: Apportionment of Medical and Other Health Services Costs

Worksheet D-1: All providers will complete this worksheet, which provides for the computation of hospital inpatient operating cost in accordance with 42 CFR 413.53 (determination of cost of services to beneficiaries), 42 CFR 413.40 (ceiling on rate of hospital cost increases), and 42 CFR 412.1 through 412.125 (prospective payment).

Worksheet D-2: Worksheet D-2 apportions the cost of services rendered by interns and residents across the following two parts:

- 1) Part I: Not in Approved Teaching Program. This part is used by the provider only if it has interns and residents that are not in an approved teaching program.

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

- 2) Part II: In an Approved Teaching Program (Title XVIII, Part B Inpatient Routine Costs Only). This part provides for reimbursement for inpatient routine services rendered by interns and residents in approved teaching programs to Medicaid beneficiaries.

Worksheet D-3: Worksheet D-3 apportions inpatient ancillary services.

Worksheet D-4: Worksheet D-4 computes organ acquisition costs and charges for hospitals that are certified transplant centers.

Worksheet D-5: Apportions cost for the services of teaching physicians.

Worksheet E

Worksheet E worksheets will be used to calculate Title XIX settlement for inpatient prospective payment system (IPPS) hospital services, medical and other health services.

NOTES:

For purposes of utilizing the CMS 2552 cost report to determine Medicare reimbursements, the term “as filed 2552 cost report” refers to the cost report filed on or before the last day of the fifth month following the close of the provider’s cost reporting period. The cost reporting period covers a 12-month period of operations based upon the provider’s accounting year.

**II. Uniform Medicaid & Uncompensated Care Cost & Charge Report (UCCR)**

In relation to Medicaid reimbursement, the CMS 2552 report does not sufficiently capture costs for Massachusetts hospitals because costs cannot be allocated across other payers, nor are costs reimbursed through the CMS 2552 inclusive of those incurred for providing the types of services that support the Medicaid-eligible and uninsured populations, such as those approved in this cost limit protocol as additional allowable costs.

The Commonwealth will use the CMS 2552<sup>2</sup> and Uniform Medicaid & Uncompensated Care Cost & Charge Report (UCCR) to determine Medicaid and uninsured costs. To supplement the CMS 2552 cost report, hospitals subject to the cost limit protocol will file the UCCR to allocate allowable 2552 costs to Medicaid

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<sup>2</sup> Community Based Detoxification Centers are the only provider type subject to the cost limit that does not submit the CMS 2552 cost report.

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

and uninsured services and, in accordance with the Cost Element table, recognize additional costs that are not otherwise reimbursed through the CMS 2552.

The UCCR report includes cost-center specific data by payer and its purpose is to capture uncompensated costs that safety net providers incur from supporting a large proportion of Medicaid and uninsured individuals. The UCCR also captures costs that are specifically allocated toward “funding required for the operation of the Safety Net Health Care System” on Schedule E, which was designed to reflect costs that are incurred disproportionately on behalf of Medicaid and uninsured patients (e.g., social, financial, and interpreter costs; unreimbursed costs for Dual Eligibles, etc. and other additional allowable costs approved in this cost limit protocol).

Overview

Acute hospitals must submit cost, charge and patient day data via the UCCR, an electronic report developed by the Commonwealth, based on the CMS 2552, and currently used to record Medicaid- and uncompensated care costs for certain safety net providers. For the Commonwealth’s use in calculating provider-specific uncompensated care cost limits, data submitted by the provider shall be based on information supplied on the hospital’s CMS 2552, as filed with and audited/settled by the Medicare fiscal intermediary, hospital records, and the UCCR.

NOTES:

The Medicaid- eligible population includes those individuals who are eligible for Medicaid but have private insurance; Medicaid FFS and Medicaid Managed Care, including individuals dually eligible for Medicaid and Medicare.

“Uninsured individuals” for whom uncompensated care costs are allowable includes the population for which HSN payments are made. Costs associated with Medicaid-eligible individuals who are uninsured for the service are allowable under this population, assuming the service meets all other criteria outlined in this protocol, including but not limited to being “medically necessary.” Additionally, costs associated with the Medicaid- eligible population must not be duplicative of the uninsured individual costs.

The costs incurred for providing the services below are approved by CMS as additional allowable services not otherwise captured and/or allocated to the Medicaid-eligible and uninsured population through the CMS 2552 allocation method.

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

For the purposes of the UCCR, a Massachusetts Medicaid Managed Care Organization (otherwise referred to as “MMCO”) includes MCOs, Integrated Care Organizations (ICOs), Senior Care Organizations (SCOs), Programs of All-inclusive Care for the Elderly (PACE), and Prepaid Inpatient or Ambulatory Health Plan (including the behavioral health PIHP).

Cost Element	Inpatient Services	Outpatient Hospital Services	Chronic Disease and Rehab – Inpatient	Chronic Disease and Rehab – Outpatient	Psychiatric Inpatient Hospital	Psychiatric Outpatient Hospital	Substance Abuse Treatment – Inpatient	Substance Abuse Treatment – Outpatient
Professional component of provider-based physician costs, including contracted physician costs, which are not part of the inpatient hospital billing	X	X	X	X	X	X		
Provider component of provider-based physician costs reduced by Medicare reasonable compensation equivalency (RCE) limits, subject to applicable Medicare cost principles	X	X	X	X	X	X		
Administrative costs of the hospital’s billing activities associated with physician services who are employees of the hospital billed and received by the hospital	X	X	X	X	X	X		



**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

Cost Element	Inpatient Services	Outpatient Hospital Services	Chronic Disease and Rehab – Inpatient	Chronic Disease and Rehab – Outpatient	Psychiatric Inpatient Hospital	Psychiatric Outpatient Hospital	Substance Abuse Treatment – Inpatient	Substance Abuse Treatment – Outpatient
Patient and community education programs, excluding cost of marketing activities	X	X	X	X	X	X	X	X
Telemedicine services	X	X	X	X	X	X	X	X
Addiction Services	X	X	X	X	X	X		X
Community Psychiatric Support and Treatment		X		X		X		X
Medication Administration		X				X		
Vision Care		X						
Health care for the house bound and the homeless, family planning, and pre-natal, labor, and post-natal support for at risk pregnancies. CMS 255-10, Line 193		X						
Social, Financial, Interpreter, Coordinated Care and other services for Medicaid-eligible and uninsured patients	X	X	X	X	X	X	X	X
340b and other pharmacy costs		X						
Graduate Medical Education	X	X	X	X	X	X		

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

Cost Element	Inpatient Services	Outpatient Hospital Services	Chronic Disease and Rehab – Inpatient	Chronic Disease and Rehab – Outpatient	Psychiatric Inpatient Hospital	Psychiatric Outpatient Hospital	Substance Abuse Treatment – Inpatient	Substance Abuse Treatment – Outpatient
Outlier Day: Each day beyond 20 acute days, during a single admission, for which a member remains hospitalized at acute status	X							
Psychiatric Day Treatment Program Services		X				X		
Dental Services		X						
Intensive Early Intervention Services for Children with Autism Spectrum Disorder	X	X						
Diversionary Behavioral Health Services	X	X	X	X	X	X	X	X
Public Hospital Pensions and Retiree Benefits	X	X						

**UCCR Instructions**

Schedule A: Computation of MassHealth Fee-for-Service (FFS) Costs

*Column 1 – Reported Costs*

Enter costs from the hospital’s most recently filed Medicare cost report (CMS 2552) Worksheet B, Part 1, column 24. This column includes costs that have already been reclassified, adjusted and stepped down through the A and B worksheet series and includes costs related to interns and residents.

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

*Column 2 – Reclassification of Observation Costs and inclusion of Post-Stepdown Costs*

Reclassify observation costs from Line 30 to Line 92. The observation costs are derived from the CMS-2552, Worksheet C, Part I, Column 5, Line 92.

Add post-step-down costs from Supplemental Worksheet B-2, Column 4, Lines 54, 60, 89 & 90, except costs related to interns and residents.

For line 30 (Adults and Pediatrics), include a decreasing adjustment, if applicable, for the swing bed costs reported on Worksheet D-1, Part I, line 26, and for the private room differential costs reported on Worksheet D-1, Part I, line 36.

*Column 3 – Total Costs*

Sum of costs from column 1 and column 2. [This column will auto-populate.]

*Column 4 – Charges*

Enter charges from the hospital's most recently filed Medicare cost report (CMS 2552) Worksheet C, Part I, column 8.

*Column 5 – Hospital Cost-to-Charge Ratios*

Calculate the cost-to-charge ratio for each cost center by dividing the total costs for each cost center from column 3 by the respective charges from column 4. [This column will auto-populate.]

*Column 6 – Total MassHealth Fee-for-Service Inpatient Charges:*

Enter from hospital records inpatient charges by cost center related to MassHealth Fee-for-Service (FFS) patients.

- MassHealth FFS Inpatient Charges include only those charges for the following:
  - Medically necessary services as defined in 130 CMR 450.204;
  - MassHealth covered inpatient hospital services provided to MassHealth patients eligible pursuant to Titles XIX and XXI at the time of service delivery.

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

- MassHealth FFS Inpatient Charges may not include:
  - Charges associated with services provided to MassHealth members where the service is covered by a Medicaid Managed Care Organization;
  - Charges associated with claims that have been final denied for payment by MassHealth;
  - Charges associated with state programs that are not Title XIX and Title XXI programs (e.g., the Children’s Medical Security Plan);
  - Charges associated with the professional component of hospital-based physician services.

*Column 7 – MassHealth FFS Inpatient Costs*

For Lines 50 through 117, calculate the MassHealth FFS inpatient costs by multiplying for each cost center the MassHealth FFS inpatient charges from column 8 by the respective hospital cost-to-charge ratios from column 5. [These lines will auto-populate.] For lines 30-46, costs are determined using a per diem methodology; these cells will automatically be populated after Schedule B (column 5) has been completed.

*Column 8 – MassHealth Fee-for-Service Outpatient Charges*

Enter from hospital records outpatient charges by cost center related to MassHealth Fee-for-Service (FFS) patients.

- MassHealth FFS Outpatient Charges include only those charges for the following:
  - Medically necessary services as defined in 130 CMR 450.204; and
  - MassHealth covered outpatient hospital services provided to MassHealth patients eligible pursuant to Titles XIX and XXI at the time of service delivery.
- MassHealth FFS Outpatient Charges may not include:
  - Charges associated with services provided to MassHealth members where the service is covered by a Medicaid Managed Care Organization;
  - Charges associated with claims that have been final denied for payment by MassHealth;
  - Charges associated with state programs that are not Title XIX or Title XXI programs (e.g., the Children’s Medical Security Plan); or

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

- Charges associated with the professional component of hospital-based physician services.

*Column 9 – MassHealth Fee-for-Service Outpatient Costs*

MassHealth FFS outpatient costs are determined by multiplying the MassHealth outpatient charges for each cost center from column 8 by the respective hospital cost-to-charge ratios from column 5. [This column will auto-populate.]

*Column 10 – Total MassHealth Fee-for-Service Inpatient and Outpatient Costs*

Total MassHealth FFS costs are determined by adding the MassHealth inpatient costs from column 7 and the MassHealth outpatient costs from column 9. [This column will auto-populate.]

Schedule B: Computation of Inpatient Routine Cost Center Per Diems

For the purposes of completing Schedule B, patient days entered in Columns 2, 4, 6 and 8 must include only those days wherein a patient fully met, at the time of service, the criteria for the given category (FFS, MMCO, HSN and Uninsured Care), as set forth in the Instructions to Schedules A and C. The SNF, NF, and LTC cost centers must be removed from Schedule B, since these costs cannot be claimed as part of the hospital uncompensated care costs.

*Column 1 – Total Routine Cost Center Inpatient Costs*

Enter total costs for each routine cost center as reported on UCCR Schedule A, Column 3, lines 30-46. [This column will auto-populate.]

*Column 2 – Total Inpatient Days*

Enter total patient days for each routine cost center from CMS-2552 Worksheet S-3, Part 1, Column 8.

*Column 3 – Per Diem*

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

Calculate the average cost per day (per diem) by dividing total costs for each cost center in column 1 by the respective total patient days in column 2. [This column will auto-populate.]

*Column 4 – MassHealth Fee-for-Service Inpatient Days*

Enter total MassHealth FFS inpatient days for each routine cost center on lines 30-46 from provider records.

*Column 5 – Total MassHealth FFS Inpatient Costs*

Calculate total FFS inpatient costs for each routine cost center by multiplying the days in column 4 by the per diem in column 3. [This column will auto-populate.]

*Column 6 – Medicaid Managed Care Inpatient Days*

Enter total Medicaid Managed Care inpatient days for each routine cost center on lines 30-46 from provider records.

*Column 7 – Total Medicaid Managed Care Inpatient Costs*

Calculate total MMCO inpatient costs for each routine cost center by multiplying the days in column 6 by the per diem in column 3. [This column will auto-populate.]

*Column 8 – HSN and Uninsured Care Inpatient Days*

Enter total HSN and Uninsured Care inpatient days for each routine cost center on lines 30-46 from provider records.

*Column 9 – Total HSN and Uninsured Care Inpatient Costs*

Calculate total HSN and Uninsured Care inpatient costs for each routine cost center by multiplying the days in column 8 by the per diem in column 3. [This column will auto-populate.]

Schedule C: Computation of Massachusetts Medicaid Managed Care (MMCO) and HSN and Uninsured Costs

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

For the purposes of completing Schedule C:

- Massachusetts Medicaid Managed Care Charges include only those charges for the following:
  - Medically necessary services as defined in 130 CMR 450.204;
  - MassHealth covered inpatient and outpatient hospital services provided to MassHealth patients eligible pursuant to Titles XIX and XXI and enrolled in a MassHealth contracting MCO, SCO, PACE, PIHP and PAHP (MMCO) at the time of service delivery.
  
- Medicaid Managed Care Charges may not include:
  - Charges associated with services provided to MassHealth members where the service is covered under MassHealth Fee-for-Service, including the Primary Care Clinician program;
  - Charges associated with claims that have been final denied for payment by the MMCO;
  - Charges associated with state programs that are not Title XIX and Title XXI programs (e.g., the Children's Medical Security Plan);
  - Charges reported as HSN and Uninsured Care (below).
  
- HSN and Uninsured Care Inpatient and Outpatient Charges are defined as those charges associated with care provided by hospitals for medically necessary services, including services reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity provided to:
  - Individuals with no health insurance coverage;
  - Low-Income Patients (under state regulation 114.6 CMR 12.03 (3) or (4) or its successor regulation) with no health insurance coverage;
  - Low-Income Patients (under state regulation 114.6 CMR 12.03 (3) or (4) or its successor regulation) whose public or private health insurance plan does not cover the cost of the particular service (excluding unpaid coinsurance and/or deductible amounts); or
  - Medicaid-eligible patients whose medical service is not paid by MassHealth or the Massachusetts Medicaid Managed Care Organizations, SCO, ICO, PACE, PIHP or PAHP;
  
- HSN and Uninsured Care Charges, for the purpose of Schedule C of the UCCR, shall exclude charges associated with:
  - Professional component of physician charges;

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

- Overhead charges related to physician services.

*Column 1 – Hospital Cost-to-Charge Ratios*

Enter the hospital cost-to-charge ratio for each cost center from Schedule A: MassHealth Fee-for-Service (FFS) Costs column 5. [This column will auto-populate.]

*Column 2 – Massachusetts Medicaid Managed Care Inpatient Charges*

Enter from hospital records inpatient charges, by cost center, related to Massachusetts Medicaid managed care patients.

*Column 3 – Massachusetts Medicaid Managed Care Inpatient Costs*

Massachusetts Medicaid managed care inpatient costs are determined by multiplying the Massachusetts Medicaid managed care inpatient charges for each cost center from column 2 by the respective hospital cost-to-charge ratios from column 1. However, for lines 30-46, costs are determined using a per diem methodology via Schedule B. [This column will auto-populate.]

*Column 4 – Massachusetts Medicaid Managed Care Outpatient Charges*

Enter from hospital records outpatient charges, by cost center, related to Massachusetts Medicaid managed care patients.

*Column 5 – Massachusetts Medicaid Managed Care Outpatient Costs*

Massachusetts Medicaid managed care outpatient costs are determined by multiplying the Massachusetts Medicaid managed care outpatient charges for each cost center from column 4 by the respective hospital cost-to-charge ratios from column 1.

*Column 6 – Total Massachusetts Medicaid Managed Care Inpatient and Outpatient Costs*

Total Massachusetts Medicaid managed care inpatient and outpatient costs are determined by adding the Massachusetts Medicaid managed care inpatient costs from column 3 and the Massachusetts Medicaid managed care outpatient costs from column 5.



**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

*Column 7 – HSN and Uninsured Care Inpatient Charges*

Enter from hospital records inpatient charges, by cost center, related to HSN and Uninsured Care patients.

*Column 8 – HSN and Uninsured Care Inpatient Costs*

For Lines 50 through 117, HSN and Uninsured Care inpatient costs are determined by multiplying the HSN and Uninsured Care inpatient charges for each cost center from column 7 by the respective hospital cost-to-charge ratios from column 1; for lines 30-46, costs are determined using a per diem methodology via Schedule B. [This column will auto-populate through line 94.]

*Column 9 – HSN and Uninsured Care Outpatient Charges*

Enter from the hospital records outpatient charges by cost center related to HSN and Uninsured Care patients.

*Column 10 – HSN and Uninsured Care Outpatient Costs*

Uncompensated care outpatient costs are determined by multiplying the HSN and Uninsured Care outpatient charges for each cost center from column 9 by the respective hospital cost-to-charge ratios from column 1.

*Column 11 – Total HSN and Uninsured Care Costs*

Total HSN and Uninsured Care inpatient and outpatient costs are determined by adding the HSN and Uninsured Care inpatient costs from column 8 and the HSN and Uninsured Care outpatient costs from column 10.

Schedule D: Computation of Uncompensated Physician Costs

For purposes of completing Schedule D:

Uncompensated Physician Costs are limited to those charges incurred by hospital-based physicians for professional services.

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

- MassHealth FFS Charges include only those charges for the following:
  - Medically necessary services as defined in 130 CMR 450.204;
  - MassHealth covered hospital-based physician professional services provided to MassHealth patients eligible pursuant to Titles XIX and XXI at the time of service delivery.
  - Charges associated with the professional component of hospital-based physicians services.
  
- MassHealth FFS Hospital-Based Physician Professional Charges may not include:
  - Charges associated with services provided to MassHealth members where the service is covered by a Medicaid Managed Care Organization;
  - Charges associated with claims that have been final denied for payment by MassHealth;
  - Charges associated with state programs that are not Title XIX and Title XXI programs (e.g., the Children's Medical Security Plan);
  
- Massachusetts Medicaid Managed Care Charges include only those charges for the following:
  - Medically necessary services as defined in 130 CMR 450.204;
  - MassHealth covered hospital-based physician professional services provided to MassHealth patients eligible pursuant to Titles XIX and XXI and enrolled in a MassHealth contracting MCO, SCO, PACE, PIHP and PAHP (MMCO) at the time of service delivery;
  - Charges associated with professional component of hospital-based physician services.
  
- Medicaid Managed Care Charges may not include:
  - Charges associated with services provided to MassHealth members where the service is covered under MassHealth Fee-for-Service, including the Primary Care Clinician program;
  - Charges associated with claims that have been final denied for payment by the MMCO;
  - Charges associated with state programs that are not Title XIX and Title XXI programs (e.g., the Children's Medical Security Plan);
  - Charges reported as HSN and Uninsured Care (below).
  
- HSN and Uninsured Physician Charges are defined as those physician charges associated with care provided for medically necessary services, including services reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity provided to:

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

- Individuals with no health insurance coverage;
- Low-Income Patients (under state regulation 114.6 CMR 12.03 (3) or (4) or its successor regulation) with no health insurance coverage;
- Low-Income Patients (under state regulation 114.6 CMR 12.03 (3) or (4) or its successor regulation) whose public or private health insurance plan does not cover the cost of a particular service (excluding unpaid coinsurance and/or deductible amounts); or
- Medicaid-eligible patients whose medical service is not paid by MassHealth or the Massachusetts Medicaid Managed Care Organizations, SCO, ICO, PACE, PIHP or PAHP;

*Column 1* – Professional Component of Physicians’ Costs

The professional component of physicians’ costs come from the hospital’s most recently filed Medicare cost report (CMS 2552) Worksheet A-8-2, column 4.

*Column 2* – Overhead Costs Related to Physicians’ Services

If the overhead costs related to physicians’ services were adjusted out of the physicians’ costs entered on Worksheet A-8-2, enter those overhead costs from Worksheet A-8 to the corresponding cost center.

*Column 3* – Total Physicians’ Costs

Total Physicians’ costs are determined by adding column 1 and column 2. [This column will auto-populate.]

*Column 4* – Total Physician Inpatient and Outpatient Charges

Enter the total charges related to physician inpatient and outpatient services from hospital records to the corresponding cost center.

*Column 5* – Cost-to-Charge Ratios

For each cost center, a cost-to-charge ratio is calculated by dividing total physicians’ costs in column 3 by total physician charges in column 4. [This column will auto-populate.]

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

*Column 6* – MassHealth FFS Physician Inpatient and Outpatient Charges

Enter by cost center the total charges related to physician inpatient and outpatient services for MassHealth FFS patients from hospital records.

*Column 7* – MassHealth FFS Physician Inpatient and Outpatient Costs

MassHealth FFS physician inpatient and outpatient costs are determined for each cost center by multiplying the MassHealth FFS inpatient and outpatient physician charges from column 6 by the cost-to-charge ratio from column 5. [This column will auto-populate.]

*Column 8* – Massachusetts Medicaid Managed Care Physician Inpatient and Outpatient Charges

Enter the total charges related to physician inpatient and outpatient services for Massachusetts Medicaid managed care patients from hospital records.

*Column 9* – Massachusetts Medicaid Managed Care Physician Inpatient and Outpatient Costs

Massachusetts Medicaid managed care physician inpatient and outpatient costs are determined for each cost center by multiplying the Massachusetts Medicaid managed care inpatient and outpatient physician charges from column 8 by the cost-to-charge ratio from column 5. [This column will auto-populate.]

*Column 10* – HSN and Uninsured Care Physician Inpatient and Outpatient Charges

From provider records, enter the charges related to physician inpatient and outpatient services for HSN and Uninsured Care patients as defined above.

*Column 11* – HSN and Uninsured Care Physician Inpatient and Outpatient Costs

HSN and Uninsured Care physician inpatient and outpatient costs are determined for each cost center by multiplying the HSN and Uninsured Care inpatient and outpatient physician charges from column 10 by the cost-to-charge ratio from column 5. [This column will auto-populate.]

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

*Column 12* – Total Massachusetts Medicaid Fee-for-Service, Medicaid Managed Care and HSN and Uninsured Care Inpatient and Outpatient Physician Costs

Total Massachusetts Medicaid fee-for-service, managed care and HSN and Uninsured Care inpatient and outpatient physician costs are determined by adding column 7, column 9 and column 11.

Schedule E: Safety Net Health Care System (SNCHS) Expenditures

Pursuant to Section 49 (c) of the 1115 demonstration Special Terms and Conditions, expenditures for payments to providers is authorized under the safety net care pool to support uncompensated care for “Medicaid FFS, Medicaid managed care, and low-income uninsured individuals.” This Schedule E provides health care providers the opportunity to itemize such system expenditures for the Medicaid-eligible and uninsured population and includes the additional allowable costs outlined in the Development Tool approved by CMS on September 6, 2013 and any additional allowable costs described in the Cost Element table of this document.

*Column 1* – Total System Expenditures

Enter total safety net health care system expenditures for each line item.

*Column 2* – Medicaid-eligible / HSN and Uninsured Payer Mix Proportion

To determine the proportion of total system expenditures attributable to Medicaid-eligible and uninsured patients, first estimate the total charges for the year attributable to this group; next, estimate the total charges for the year attributable to all patients served by the SNHCS. The ratio of these two numbers will be used to estimate the amount of system expenditures attributable to Medicaid-eligible and uninsured patients. Enter this ratio in column 2. Should an alternative ratio be more appropriate, enter that number, and then explain the basis for it in the Narrative Description section of Schedule E.

*Column 3* – Medicaid-eligible / HSN and Uninsured Share of System Expenditures

Calculate the system expenditures attributable to Medicaid-eligible and uninsured patients by multiplying the total system expenditure in column 1 by the payer mix proportion in column 2. [This column will auto-populate.]

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

Schedule F: Medicaid and Uninsured Revenue

Note: Hospitals must ensure that any applicable revenues pertaining to Medicaid or uninsured costs allowed in Schedule E are captured in Schedule F and are treated as an offset to arrive at net uncompensated care costs.

Line Instructions:

Hospital and Clinic Revenue:

In lines 1-8, enter amounts paid for services provided by the hospital and any provider-based satellites, including hospital-licensed health centers.

Line 1 – Payer Medical Claims Revenue

For each column, enter in line 1 the total amount paid by the payer for medical claims. Do not include payments for that are not related to claims, such as pay-for-performance payments or supplemental payments. The amounts reported must reflect any post-payment reconciliations or recoupments, subject to the availability of that data.

Column 5 - Health Safety Net and Uninsured

In line 1, column 5, report the gross payments received from the HSN and Uninsured. Do not offset the amount of the HSN Assessment.

Line 2 – Pay-for-Performance / Incentive Payment Revenue

This revenue data is reported for informational purposes only. Payments that are not service payments for the provision of medical care are not offset against the eligible cost. Since the following payments are not payments for the provision of medical care, they are not offset against the eligible cost: SNCP grants and performance-based, incentive, and shared savings payments. These include performance-based and incentive-based payments and grants and awards both currently in existence and those that may be approved and implemented during future demonstration renewal periods.

Enter in line 2 any amounts paid by the payer for pay-for-performance or other incentive payments. The amount reported must also include any recoveries made by the payer for performance issue, such as retrospective performance penalties.

Line 3-5 – Supplemental Payments

Enter in lines 3-5 any amounts paid by the payer for supplemental payments. Specify the type of supplemental payment reported by modifying the title of the line. The total

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

gross payment must be reported; do not offset any payment amount by any intergovernmental transfer amounts that may have been made by a related public entity.

**Line 6 – Medicare Revenue**

Enter in line 6 any payments amounts received by Medicare for services provided to patients who are eligible for both Medicare and the payer noted in the column.

**Line 7 – Third Party and Self Pay Revenue**

Enter in line 7 any payment amounts received by third parties, the patient, or the patient's guarantor for the cost-sharing or services not covered by the payer noted in the column.

**Line 8 – Other Revenue**

Enter in line 8 any additional revenue from the payer for the Medicaid-eligible and uninsured populations not included in lines 1-7. Specify the type of revenue by modifying the title of the line. Additional information may be provided in the Notes tab.

**Line 9 – Subtotal Hospital and Clinic**

Sum of lines 1-8. [This line will auto-populate.]

**Lines 10-15 Physician Revenue**

Using the same descriptions in the corresponding lines 1-8, report physician revenue related to the payers.

**Line 16 – Subtotal Physician Revenue**

Sum of lines 10-15. [This line will auto-populate.]

**Line 17 – Total Revenue.**

Sum of lines 9 and 16. [This line will auto-populate.]

**Column Instructions.**

***Column 1* – Medicaid FFS Inpatient Revenue**

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

Report in column 1, amounts paid by MassHealth for inpatient services provided to members enrolled in the MassHealth program, excluding those enrolled in MassHealth managed care programs.

*Column 2 – Medicaid FFS Outpatient Revenue*

Report in column 2, amounts paid by MassHealth for outpatient services provided to members enrolled in the MassHealth program, excluding those enrolled in MassHealth managed care programs.

*Column 3 – Medicaid Managed Care Inpatient Revenue*

Report in column 3, amounts paid by Medicaid Managed Care Organizations for inpatient services provided to members.

*Column 4 – Medicaid Managed Care Outpatient Revenue*

Report in column 4, amounts paid by Medicaid Managed Care Organizations for outpatient services provided to members.

*Column 5 – HSN and Uninsured Inpatient and Outpatient Revenue*

Report in column 5, amounts paid by the HSN and uninsured individuals for inpatient and outpatient services provided. Report the gross payments received from the HSN. Do not offset the amount of the HSN Assessment.

*Column 6 – Total Revenue*

Sum of columns 1 through 5. [This column will auto-populate.]

Schedule G: Notes

Providers may use Schedule G to provide additional information on the data reported.

**III. Reconciliation**



**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

Interim Reconciliation

Each provider's uncompensated care costs must be computed based on the provider's as-filed CMS 2552<sup>3</sup> cost report and Uniform Medicaid & Uncompensated Care Cost & Charge Report (UCCR) and for the actual service period. The CMS 2552 cost report is filed with the Medicare contractor five months after the close of the cost reporting period. The UCCR must be filed three months after the CMS 2552 is filed. For SNCP payments subject to the cost limit pursuant to STC 49(c), each provider's allowable Medicaid, uncompensated care, and uninsured costs must be reconciled against associated applicable payments received for the year for which the payments were made.

For hospitals whose accounting fiscal year aligns with the cost limit reporting fiscal year (Federal fiscal year), the Medicaid and uninsured costs will be reflected in the CMS 2552 and UCCR that is submitted for the accounting fiscal year. For acute hospitals whose accounting fiscal years do not align with the reporting fiscal year, the reporting year cost limit will be calculated by applying the appropriate percentage of the two contiguous CMS 2552 and UCCR cost reports that span the reporting fiscal year so that the Federal fiscal year will be represented in the cost limit calculation.

The Commonwealth must recover provider overpayments as it determines necessary based on its reconciliation calculations and availability of federal financial participation.

If an overpayment exists, the Commonwealth must determine if the overpayment occurred due to Health Safety Net (HSN) Trust Fund payments or other SNCP payments, or from both payments. To the extent that the overpayment is a result of overpaid funds from the HSN Trust Fund payments, the Commonwealth must recover from the provider the amount overpaid to the provider from the HSN Trust Fund and credit that amount to the HSN Trust Fund. The HSN Trust Fund will redistribute such amounts to other providers as appropriate. To the extent that the overpayment is not the result of HSN Trust Fund payments, the Commonwealth must recover from the provider the overpayment, and the Commonwealth must properly credit the federal share to the federal government.

The interim reconciliation described above must be performed and completed within twelve months after the filing of the UCCR(s).

Final Reconciliation

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<sup>3</sup> Community Based Detoxification Centers are the only provider type subject to the cost limit that does not submit the CMS 2552 cost report.

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

Each provider's uncompensated care costs must be recomputed based on the provider's audited CMS 2552 cost report for the actual service period. These recomputed costs must be carried over to the UCCR. The CMS 2552 cost report is audited and settled by the Medicare contractor to determine final allowable costs and reimbursement amounts as recognized by Medicare. For SNCP payments subject to the cost limit pursuant to STC 49(c), each provider's allowable Medicaid, uncompensated care, and uninsured costs must be reconciled against associated applicable payments received for the year for which the payments were made. SNCP uncompensated care payments made to the provider for a cost limit reporting year cannot exceed the recomputed uncompensated care cost limit. If, at the end of the final reconciliation process, it is determined that expenditures claimed exceeded the individual provider's uncompensated care cost limit, thereby causing an overpayment, the Commonwealth must recoup the overpayment from the provider. Specifically, if an overpayment exists, the Commonwealth must determine if the overpayment occurred due to HSN Trust Fund payments or other SNCP payments, or from both payments. To the extent that the overpayment is a result of overpaid funds from the HSN Trust Fund, the Commonwealth must recover from the provider the amount overpaid to the provider from the HSN Trust Fund and credit that amount to the HSN Trust Fund. The HSN Trust Fund will redistribute such amounts to other providers as appropriate. To the extent that the overpayment is not the result of HSN Trust Fund payments, the Commonwealth must recover from the provider the overpayment, and the Commonwealth must properly credit the federal share to the federal government.

For hospitals whose accounting fiscal year aligns with the cost limit reporting fiscal year (Federal fiscal year), the Medicaid and uninsured costs will be reflected in the CMS 2552 and UCCR that is submitted for the accounting fiscal year. For acute hospitals whose accounting fiscal years do not align with the reporting fiscal year, the reporting year cost limit will be calculated by applying the appropriate percentage of the two contiguous CMS 2552 and UCCR cost reports that span the reporting fiscal year so that the Federal fiscal year will be represented in the cost limit calculation.

The Commonwealth must recover provider overpayments as it determines necessary based on its reconciliation calculations and availability of federal financial participation.

The final reconciliation described above must be performed and completed within twelve months after all final, audited CMS 2552 cost reports become available online.

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

**Public Chronic Disease & Rehabilitation and Psychiatric Inpatient and Outpatient  
Hospital Protocol for Medicaid and Uncompensated Care Cost**

Determination of Allowable Medicaid and Uninsured Costs

- a. DSH Allowable Costs
  - i. Per STC 50(f), the cost limit protocol will use the Medicaid DSH statutory, regulatory, and policy definitions of allowable inpatient hospital and outpatient hospital services and allowable Medicaid and uninsured costs in determining hospital-specific cost limits. To the extent that the determination of uncompensated care costs varies from the Medicaid DSH requirements, the process must be accounted for in this document.
  - ii. Allowable pharmacy costs include the cost of drugs and pharmacy supplies requested by patient care departments and drugs charged to patients. Pharmacy service costs that are not part of an inpatient or outpatient service, such as retail pharmacy costs, are not considered eligible for inclusion in the hospital-specific uncompensated cost limit allowable under DSH. To the extent that the determination of allowable pharmacy costs varies from the Medicaid DSH requirements, the process must be accounted for in this document.
  - iii. Costs included must be for services that meet the federal definition and the approved Massachusetts State plan definition of “hospital services” for medical assistance. “Medical assistance” is defined as the cost of care and services “for individuals, and, with respect to physicians’ or dentists’ services, at the option of the State, to individuals [who are eligible]...” Section 1905 of the Act.
- b. Medicaid State Plan Allowable Costs
  - i. Massachusetts must use the same definition for all inpatient hospital, outpatient hospital, and physician services, clinic services, non-hospital services, etc. as described in its approved Medicaid state plan, and in accordance with Section 1905 of the Social Security Act and the regulations promulgated thereunder, to define allowable service costs provided by inpatient and outpatient hospitals. Massachusetts identifies other service costs, subject to CMS approval, that are not included in the Medicaid state plan definitions to be included as allowable uncompensated care costs in this document (see Cost Element table).
    - 1. Inpatient chronic disease and rehabilitation hospital services: Inpatient services are routine and ancillary services that are provided to recipients admitted as patients to a chronic disease or rehabilitation hospital. Such services

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

- are as described in Section 1905 of the Social Security Act and the regulations promulgated thereunder.
2. Inpatient psychiatric hospital services: Psychiatric treatment provided under the direction of a psychiatrist in a psychiatric inpatient hospital. Such services are as described in Section 1905 of the Social Security Act and the regulations promulgated thereunder.
  3. Outpatient chronic disease and rehabilitation hospital services: Rehabilitative and medical services provided to a member in a chronic disease or rehabilitation outpatient setting including but not limited to chronic disease or rehabilitation hospital outpatient departments, hospital-licensed health centers or other hospital satellite clinics, physicians' offices, nurse practitioners' offices, freestanding ambulatory surgery centers, day treatment centers, or the member's home. Such services include, but are not limited to, radiology, laboratory, diagnostic testing, therapy services (i.e., physical, speech, occupational and respiratory) and Day surgery services. Such services are as described in Section 1905 of the Social Security Act and the regulations promulgated thereunder.
  4. Outpatient psychiatric hospital services: Services provided to members on an outpatient basis in a psychiatric hospital. Such services are as described in Section 1905 of the Social Security Act and the regulations promulgated thereunder.
- c. 1115 Demonstration Allowable Costs
- i. 1115 Demonstration Expenditures: Costs incurred by psychiatric and chronic disease and rehabilitation hospitals for providing services to members eligible for Medicaid through the section 1115 demonstration (i.e., expansion populations) will be counted as allowable costs. In addition, allowable costs of services that are not authorized under the 1115 demonstration include expenditures related to services provided in the programs below and described in the Cost Element table. All services authorized under the section 1115 demonstration are subject to the requirements and limitations specified in the STCs.
    1. Diversionary Behavioral Health Services.
  - d. Medicaid Managed Care Costs: Costs incurred by psychiatric and chronic disease and rehabilitation hospitals for providing services to members enrolled in Medicaid managed care organizations including SCOs and ICOs, prepaid inpatient health plans, and any prepaid ambulatory health plans. Eligible costs are determined using the same methodology under this section.

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

- e. Other Allowable Costs, Approved 1915(c) Waivers – Allowable costs are defined in the Cost Element table.
- f. Additional Allowable Costs – Allowable costs are defined in the Cost Element table.

**I. Certified Public Expenditures – Determination of Allowable Safety Net Care Pool Costs**

In accordance with the approved MassHealth Section 1115 demonstration, beginning July 1, 2014, the estimated fiscal year expenditures will be based on the actual fiscal year CMS 2552 and UCCR cost reports.

General Description of Methodology

The certified public expenditures (CPEs) for special population State-Owned Non-Acute hospitals operated by the Department of Public Health (DPH) and Department of Mental Health (DMH) are claimed annually under the Safety Net Care Pool (SNCP) based upon the unreimbursed Medicaid and uninsured. The CPE interim payments made under the SNCP will follow the same methodology as contained in the Commonwealth's Medicaid State Plan.

**II. Summary of 2552-10 Cost Report**

Worksheet A: Reclassification and Adjustment of Trial Balance of Expenses

Worksheet A provides for recording the trial balance of expense accounts from your accounting books and records. It also provides for the necessary reclassifications and adjustments to certain accounts. Not included on Worksheet A are items that conflict with Medicare regulations, manuals, or instructions but which providers may wish to claim and contest.

The trial balance of expenses is broken down into the following categories to facilitate the transfer of costs to the various worksheets:

- 1) General service cost centers
- 2) Inpatient routine service cost centers
- 3) Ancillary service cost centers
- 4) Outpatient service cost centers
- 5) Other reimbursable cost centers
- 6) Special purpose cost centers
- 7) Other special purpose cost centers not previously identified
- 8) Costs applicable to nonreimbursable cost centers to which general service costs apply

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

- 9) Nonreimbursable cost center to accumulate the cost incurred by you for services related to the physicians' private practice

Worksheet B

Worksheet B allocates overhead (originally identified as general service cost centers) to all other cost centers, including the non-reimbursable costs identified in lines 96 through 100.

Cost finding is the process of recasting data derived from the accounts ordinarily kept by the provider to ascertain costs of the various types of services rendered; i.e., the allocation of the expenses of each general service cost center to those cost centers which receive the services. The CMS 2552 approved method of cost finding is recognized and outlined in 42 CFR 413.24 and is based on the accrual basis of accounting except where government institutions operate on a cash basis of accounting.

Worksheet C

Worksheet C computes the ratio of cost to charges (RCC) for inpatient services, ancillary services, outpatient services, and other reimbursable services. The total cost for each cost center is derived from Worksheet B after the overhead allocation, and the total charge for each cost center is determined from the provider's records. This RCC is used on Worksheet D, Worksheet D-3, Worksheet D-4, Worksheet H-3, and Worksheet J-2 to determine the program's share of ancillary service costs in accordance with 42 CFR 413.53. This worksheet is also needed to determine the adjusted total costs used on Worksheet D-1.

Worksheet D

This series of worksheets is where the total costs from Worksheet B are apportioned to different payer programs. Apportionment is the process by which a cost center's total cost is allocated to a specific payer or program or service type. Apportionment is used to arrive at Medicare hospital inpatient routine and ancillary cost and Medicare hospital outpatient cost, etc.

Worksheet D consists of the following five parts:

- 1) Part I: Apportionment of Inpatient Routine Service Capital Costs
- 2) Part II: Apportionment of Inpatient Ancillary Service Capital Costs
- 3) Part III: Apportionment of Inpatient Routine Service Other Pass Through Costs
- 4) Part IV: Apportionment of Inpatient/Outpatient Ancillary Service Other Pass Through Costs
- 5) Part V: Apportionment of Medical and Other Health Services Costs

Worksheet D-1: All providers will complete this worksheet, which provides for the computation of hospital inpatient operating cost in accordance with 42 CFR 413.53

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

(determination of cost of services to beneficiaries), 42 CFR 413.40 (ceiling on rate of hospital cost increases), and 42 CFR 412.1 through 412.125 (prospective payment).

Worksheet D-2: Worksheet D-2 apportions the cost of services rendered by interns and residents across the following two parts:

- 1) Part I: Not in Approved Teaching Program. This part is used by the provider only if it has interns and residents that are not in an approved teaching program.
- 2) Part II: In an Approved Teaching Program (Title XVIII, Part B Inpatient Routine Costs Only). This part provides for reimbursement for inpatient routine services rendered by interns and residents in approved teaching programs to Medicaid beneficiaries.

Worksheet D-3: Worksheet D-3 apportions inpatient ancillary services.

Worksheet D-4: Worksheet D-4 computes organ acquisition costs and charges for hospitals that are certified transplant centers.

Worksheet D-5: Apportions cost for the services of teaching physicians.

Worksheet E

Worksheet E worksheets will be used to calculate Title XIX settlement for inpatient prospective payment system (IPPS) hospital services, medical and other health services.

NOTES:

For purposes of utilizing the CMS 2552 cost report to determine Medicare reimbursements, the term “as filed 2552 cost report” refers to the cost report filed on or before the last day of the fifth month following the close of the provider’s cost reporting period. The cost reporting period covers a 12-month period of operations based upon the provider’s accounting year.

**III. Uniform Medicaid & Uncompensated Care Cost & Charge Report (UCCR)**

In relation to Medicaid reimbursement, the CMS 2552 report does not sufficiently capture costs for Massachusetts providers because costs cannot be allocated across other payers, nor are costs reimbursed through the CMS 2552 inclusive of those incurred for providing the types of services that support the Medicaid-eligible and uninsured populations, such as those approved in this cost limit protocol as additional allowable costs.

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

The Commonwealth will use the CMS 2552<sup>4</sup> and Uniform Medicaid & Uncompensated Care Cost & Charge Report (UCCR) to determine Medicaid and uninsured costs. To supplement the Medicare 2552 cost report, hospitals subject to the cost protocol will file the UCCR to allocate allowable 2552 costs to Medicaid and uninsured services and, in accordance with the Cost Element table, recognize additional costs that are not otherwise reimbursed through the CMS 2552.

The UCCR report includes cost-center specific data by payer and its purpose is to capture uncompensated costs that safety net providers incur from supporting a large proportion of Medicaid-eligible and uninsured individuals. The UCCR also captures costs that are specifically allocated toward “funding required for the operation of the Safety Net Health Care System” on Schedule E, which was designed to reflect costs that are incurred disproportionately on behalf of Medicaid-eligible and uninsured patients (e.g., social, financial, and interpreter costs; unreimbursed costs for Dual Eligibles, etc. and other additional allowable costs approved in this cost limit protocol).

Overview

Public Chronic Disease & Rehabilitation and Psychiatric Inpatient and Outpatient Hospitals must submit cost, charge and patient day data via the UCCR, an electronic report developed by the Commonwealth based on the 2552 and currently used to record Medicaid and uncompensated care costs for certain safety net providers. For the Commonwealth’s use in calculating provider-specific uncompensated care cost limits, data submitted by the provider shall be based on information supplied on the hospital’s CMS 2552, as filed with and audited/settled by the Medicare fiscal intermediary, hospital records, and the UCCR.

NOTES:

The Medicaid-eligible population includes those who are eligible for Medicaid but have private insurance; Medicaid FFS and Medicaid Managed Care, including individuals dually eligible for Medicaid and Medicare.

“Uninsured individuals” for whom uncompensated care costs are allowable includes the population for which HSN payments are made. Costs associated with Medicaid-eligible individuals who are uninsured for the service are allowable under this population, assuming the service meets all other criteria outlined in this protocol, including but not limited to being “medically necessary.”

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<sup>4</sup> Community Based Detoxification Centers are the only provider type subject to the cost limit that does not submit the Medicare 2552 cost report.



**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

Additionally, costs associated with the Medicaid-eligible population must not be duplicative of the uninsured individual costs.

The costs incurred for providing the services below are approved by CMS as additional allowable services not otherwise captured and/or allocated to the Medicaid-eligible and uninsured population through the CMS 2552 allocation method.

For the purposes of the UCCR, a Massachusetts Medicaid Managed Care Organization (otherwise referred to as “MMCO”) includes MCOs, Integrated Care Organizations (ICOs), Senior Care Organizations (SCOs), Programs of All-inclusive Care for the Elderly (PACE), and Prepaid Inpatient or Ambulatory Health Plan (including the behavioral health PIHP).

Cost Element	Inpatient Services	Outpatient Hospital Services	Chronic Disease and Rehab – Inpatient	Chronic Disease and Rehab – Outpatient	Psychiatric Inpatient Hospital	Psychiatric Outpatient Hospital	Substance Abuse Treatment – Inpatient	Substance Abuse Treatment – Outpatient
Professional component of provider-based physician costs, including contracted physician costs, which are not part of the inpatient hospital billing	X	X	X	X	X	X		
Provider component of provider-based physician costs reduced by Medicare reasonable compensation equivalency (RCE) limits, subject to applicable Medicare cost principles	X	X	X	X	X	X		
Administrative costs of the hospital’s billing activities	X	X	X	X	X	X		

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

Cost Element	Inpatient Services	Outpatient Hospital Services	Chronic Disease and Rehab – Inpatient	Chronic Disease and Rehab – Outpatient	Psychiatric Inpatient Hospital	Psychiatric Outpatient Hospital	Substance Abuse Treatment – Inpatient	Substance Abuse Treatment – Outpatient
associated with physician services who are employees of the hospital billed and received by the hospital								
Patient and community education programs, excluding cost of marketing activities	X	X	X	X	X	X	X	X
Telemedicine services	X	X	X	X	X	X	X	X
Addiction Services	X	X	X	X	X	X		X
Community Psychiatric Support and Treatment		X		X		X		X
Medication Administration		X				X		
Vision Care		X						
Health care for the house bound and the homeless, family planning, and pre-natal, labor, and post-natal support for at risk pregnancies. CMS 255-10, Line 193		X						
Social, Financial, Interpreter, Coordinated Care and other services for Medicaid-eligible and	X	X	X	X	X	X	X	X

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

Cost Element	Inpatient Services	Outpatient Hospital Services	Chronic Disease and Rehab – Inpatient	Chronic Disease and Rehab – Outpatient	Psychiatric Inpatient Hospital	Psychiatric Outpatient Hospital	Substance Abuse Treatment – Inpatient	Substance Abuse Treatment – Outpatient
uninsured patients								
340b and other pharmacy costs		X						
Graduate Medical Education	X	X	X	X	X	X		
Outlier Day: Each day beyond 20 acute days, during a single admission, for which a member remains hospitalized at acute status	X							
Psychiatric Day Treatment Program Services		X				X		
Dental Services		X						
Intensive Early Intervention Services for Children with Autism Spectrum Disorder	X	X						
Diversionsary Behavioral Health Services	X	X	X	X	X	X	X	X
Public Hospital Pensions and Retiree Benefits	X	X						

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

**UCCR Instructions**

Schedule A: Computation of MassHealth Fee-for-Service (FFS) Costs

*Column 1 – Reported Costs*

Enter costs from the hospital's most recently filed Medicare cost report (CMS 2552) Worksheet B, Part 1, column 24. This column includes costs that have already been reclassified, adjusted and stepped down through the A and B worksheet series and includes costs related to interns and residents.

*Column 2 – Reclassification of Observation Costs and Inclusion of Post-Stepdown Costs*

Reclassify observation costs from Line 30 to Line 92. The observation costs are derived from the CMS-2552, Worksheet C, Part I, Column 5, Line 92.

Add post-step-down costs from Supplemental Worksheet B-2, Column 4, Lines 54, 60, 89 & 90, except costs related to interns and residents.

For line 30 (Adults and Pediatrics), include a decreasing adjustment, if applicable, for the swing bed costs reported on Worksheet D-1, Part I, line 26, and for the private room differential costs reported on Worksheet D-1, Part I, line 36.

*Column 3 – Total Costs*

Sum of costs from column 1 and column 2. [This column will auto-populate.]

*Column 4 – Charges*

Enter charges from the hospital's most recently filed Medicare cost report (CMS 2552) Worksheet C, Part I, column 8.

*Column 5 – Hospital Cost-to-Charge Ratios*

Calculate the cost-to-charge ratio for each cost center by dividing the total costs for each cost center from column 3 by the respective charges from column 4. [This column will auto-populate.]

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

*Column 6* – Total MassHealth Fee-for-Service Inpatient Charges:

Enter from hospital records inpatient charges by cost center related to MassHealth Fee-for-Service (FFS) patients.

- MassHealth FFS Charges include only those charges for the following:
  - Medically necessary services as defined in 130 CMR 450.204;
  - MassHealth covered inpatient hospital services provided to MassHealth patients eligible pursuant to Titles XIX and XXI at the time of service delivery.
  
- MassHealth FFS Charges may not include:
  - Charges associated with services provided to MassHealth members where the service is covered by a Medicaid Managed Care Organization;
  - Charges associated with claims that have been final denied for payment by MassHealth;
  - Charges associated with state programs that are not Title XIX and Title XXI programs (e.g., the Children’s Medical Security Plan);
  - Charges associated with the professional component of hospital-based physician services.

*Column 7* – MassHealth FFS Inpatient Costs

For Lines 50 through 117, calculate the MassHealth FFS inpatient costs by multiplying for each cost center the MassHealth FFS inpatient charges from column 8 by the respective hospital cost-to-charge ratios from column 5. [These lines will auto-populate.] For lines 30-46, costs are determined using a per diem methodology; these cells will automatically be populated after Schedule B (column 5) has been completed.

*Column 8* – MassHealth Fee-for-Service Outpatient Charges

Enter from hospital records outpatient charges by cost center related to MassHealth Fee-for-Service (FFS) patients.

- MassHealth FFS Outpatient Charges include only those charges for the following:
  - Medically necessary services as defined in 130 CMR 450.204;

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

- MassHealth covered outpatient hospital services provided to MassHealth patients eligible pursuant to Titles XIX and XXI at the time of service delivery.
- MassHealth FFS Outpatient Charges may not include:
  - Charges associated with services provided to MassHealth members where the service is covered by a Medicaid Managed Care Organization;
  - Charges associated with claims that have been final denied for payment by MassHealth;
  - Charges associated with state programs that are not Title XIX or Title XXI programs (e.g., the Children's Medical Security Plan);
  - Charges associated with the professional component of hospital-based physician services.

*Column 9 – MassHealth Fee-for-Service Outpatient Costs*

MassHealth FFS outpatient costs are determined by multiplying the MassHealth outpatient charges for each cost center from column 8 by the respective hospital cost-to-charge ratios from column 5. [This column will auto-populate.]

*Column 10 – Total MassHealth Fee-for-Service Inpatient and Outpatient Costs*

Total MassHealth FFS costs are determined by adding the MassHealth inpatient costs from column 7 and the MassHealth outpatient costs from column 11. [This column will auto-populate.]

Schedule B: Computation of Inpatient Routine Cost Center Per Diems

For the purposes of completing Schedule B, patient days entered in Columns 2, 4, 6 and 8 must include only those days wherein a patient fully met, at the time of service, the criteria for the given category (FFS, MMCO, HSN and Uninsured Care), as set forth in the Instructions to Schedules A and C.

*Column 1 – Total Routine Cost Center Inpatient Costs*

Enter total costs for each routine cost center as reported on UCCR Schedule A, Column 3, lines 30-46. [This column will auto-populate.]

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

*Column 2 – Total Inpatient Days*

Enter total patient days for each routine cost center from CMS-2552 Worksheet S-3, Part 1, Column 8.

*Column 3 – Per Diem*

Calculate the average cost per day (per diem) by dividing total costs for each cost center in column 1 by the respective total patient days in column 2. [This column will auto-populate.]

*Column 4 – MassHealth Fee-for-Service Inpatient Days*

Enter total MassHealth FFS inpatient days for each routine cost center on lines 30-46 from provider records.

*Column 5 – Total MassHealth FFS Inpatient Costs*

Calculate total FFS inpatient costs for each routine cost center by multiplying the days in column 4 by the per diem in column 3. [This column will auto-populate.]

*Column 6 – Medicaid Managed Care Inpatient Days*

Enter total MassHealth managed care inpatient days for each routine cost center on lines 30-46 from provider records.

*Column 7 – Total Medicaid Managed Care Inpatient Costs*

Calculate total MMCO inpatient costs for each routine cost center by multiplying the days in column 6 by the per diem in column 3. [This column will auto-populate.]

*Column 8 – HSN and Uninsured Care Inpatient Days*

Enter total HSN and Uninsured Care inpatient days for each routine cost center on lines 30-46 from provider records.

*Column 9 – Total HSN and Uninsured Care Inpatient Costs*

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

Calculate total HSN and Uninsured Care inpatient costs for each routine cost center by multiplying the days in column 8 by the per diem in column 3. [This column will auto-populate.]

Schedule C: Computation of Massachusetts Medicaid Managed Care (MMCO) and HSN and Uninsured Costs

For the purposes of completing Schedule C:

- Massachusetts Medicaid Managed Care Charges include only those charges for the following:
  - Medically necessary services as defined in 130 CMR 450.204;
  - MassHealth covered inpatient and outpatient hospital services provided to MassHealth patients eligible pursuant to Titles XIX and XXI and enrolled in a MassHealth contracting MCO, SCO, PACE, PIHP and PAHP (MMCO) at the time of service delivery.
- Medicaid Managed Care Charges may not include:
  - Charges associated with services provided to MassHealth members where the service is covered under MassHealth Fee-for-Service, including the Primary Care Clinician program;
  - Charges associated with claims that have been final denied for payment by the MMCO;
  - Charges associated with state programs that are not Title XIX and Title XXI programs (e.g., the Children's Medical Security Plan);
  - Charges associated with patients eligible for another state's Medicaid program;
  - Charges reported as HSN and Uninsured Care (below).
- HSN and Uninsured Care Inpatient and Outpatient Charges are defined as those charges associated with care provided by hospitals for medically necessary services, including services reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity provided to:
  - Individuals with no health insurance coverage;
  - Low-Income Patients (under state regulation 114.6 CMR 12.03 (3) or (4) or its successor regulation) with no health insurance coverage;
  - Low-Income Patients (under state regulation 114.6 CMR 12.03 (3) or (4) or its successor regulation) whose public or private health



**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

- insurance plan does not cover the cost of the particular service (excluding unpaid coinsurance and/or deductible amounts); or
- Medicaid-eligible patients whose medical service is not paid by MassHealth or the Massachusetts Medicaid Managed Care Organizations, SCO, ICO, PACE, PIHP or PAHP;
- HSN and Uninsured Care Charges, for the purpose of Schedule C of the UCCR, shall exclude charges associated with:
  - Professional component of physician charges;
  - Overhead charges related to physician services.

*Column 1 – Hospital Cost-to-Charge Ratios*

Enter the hospital cost-to-charge ratio for each cost center from Schedule A: MassHealth Fee-for-Service (FFS) Costs column 5. [This column will auto-populate.]

*Column 2 – Massachusetts Medicaid Managed Care Inpatient Charges*

Enter from hospital records inpatient charges, by cost center, related to Massachusetts Medicaid managed care patients.

*Column 3 – Massachusetts Medicaid Managed Care Inpatient Costs*

Massachusetts Medicaid managed care inpatient costs are determined by multiplying the Massachusetts Medicaid managed care inpatient charges for each cost center from column 2 by the respective hospital cost-to-charge ratios from column 1. However, for lines 30-46, costs are determined using a per diem methodology via Schedule B. [This column will auto-populate.]

*Column 4 – Massachusetts Medicaid Managed Care Outpatient Charges*

Enter from hospital records outpatient charges, by cost center, related to Massachusetts Medicaid managed care patients.

*Column 5 – Massachusetts Medicaid Managed Care Outpatient Costs*

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

Massachusetts Medicaid managed care outpatient costs are determined by multiplying the Massachusetts Medicaid managed care outpatient charges for each cost center from column 4 by the respective hospital cost-to-charge ratios from column 1.

*Column 6* – Total Massachusetts Medicaid managed care Inpatient and Outpatient Costs

Total Massachusetts Medicaid managed care inpatient and outpatient costs are determined by adding the Massachusetts Medicaid managed care inpatient costs from column 3 and the Massachusetts Medicaid managed care outpatient costs from column 5.

*Column 7* – HSN and Uninsured Care Inpatient Charges

Enter from hospital records inpatient charges, by cost center, related to HSN and Uninsured Care patients.

*Column 8* – HSN and Uninsured Care Inpatient Costs

For Lines 50 through 117, HSN and Uninsured Care inpatient costs are determined by multiplying the HSN and Uninsured Care inpatient charges for each cost center from column 7 by the respective hospital cost-to-charge ratios from column 1; for lines 30-46, costs are determined using a per diem methodology via Schedule B. [This column will auto-populate through line 94.]

*Column 9* – HSN and Uninsured Care Outpatient Charges

Enter from the hospital records outpatient charges by cost center related to HSN and Uninsured Care patients.

*Column 10* – HSN and Uninsured Care Outpatient Costs

HSN and Uninsured Care outpatient costs are determined by multiplying the HSN and Uninsured Care outpatient charges for each cost center from column 9 by the respective hospital cost-to-charge ratios from column 1.

*Column 11* – Total HSN and Uninsured Care Inpatient and Outpatient Costs

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

Total HSN and Uninsured Care inpatient and outpatient costs are determined by adding the HSN and Uninsured Care inpatient costs from column 8 and the HSN and Uninsured Care outpatient costs from column 10.

Schedule D: Computation of Uncompensated Physician Costs

For purposes of completing Schedule D:

Uncompensated Physician Costs are limited to those charges incurred by hospital-based physicians for professional services.

- MassHealth FFS Inpatient and Outpatient Charges include only those charges for the following:
  - Medically necessary services as defined in 130 CMR 450.204;
  - MassHealth covered hospital-based physician professional services provided to MassHealth patients eligible pursuant to Titles XIX and XXI at the time of service delivery.
  - Charges associated with the professional component of hospital-based physician services.
- MassHealth FFS Hospital-Based Physician Professional Charges may not include:
  - Charges associated with services provided to MassHealth members where the service is covered by a Medicaid Managed Care Organization;
  - Charges associated with claims that have been final denied for payment by MassHealth;
  - Charges associated with state programs that are not Title XIX and Title XXI programs (e.g., the Children's Medical Security Plan);
- Massachusetts Medicaid Managed Care Charges include only those charges for the following:
  - Medically necessary services as defined in 130 CMR 450.204;
  - MassHealth covered hospital-based physician services provided to MassHealth patients eligible pursuant to Titles XIX and XXI and enrolled in a MassHealth contracting MCO, SCO, PACE, PIHP and PAHP (MMCO) at the time of service delivery.
- Medicaid Managed Care Charges may not include:
  - Charges associated with services provided to MassHealth members where the service is covered under MassHealth Fee-for-Service, including the Primary Care Clinician program;

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

- Charges associated with claims that have been final denied for payment by the MMCO;
  - Charges associated with state programs that are not Title XIX and Title XXI programs (e.g., the Children's Medical Security Plan);
  - Charges reported as HSN and Uninsured Care (below).
- HSN and Uninsured Care Physician Charges are defined as those physician charges associated with care provided for medically necessary services, including services reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity provided to:
    - Individuals with no health insurance coverage;
    - Low-Income Patients (under state regulation 114.6 CMR 12.03 (3) or (4) or its successor regulation) with no health insurance coverage;
    - Low-Income Patients (under state regulation 114.6 CMR 12.03 (3) or (4) or its successor regulation) whose public or private health insurance plan does not cover the cost of the particular service (excluding unpaid coinsurance and/or deductible amounts); or
    - Medicaid-eligible patients whose medical service is not paid by MassHealth or the Massachusetts Medicaid Managed Care Organizations, SCO, ICO, PACE, PIHP or PAHP;

*Column 1 – Professional Component of Physicians' Costs*

The professional component of physicians' costs come from the hospital's most recently filed Medicare cost report (CMS 2552) Worksheet A-8-2, column 4.

*Column 2 – Overhead Costs Related to Physicians' Services*

If the overhead costs related to physicians' services were adjusted out of the physicians' costs entered on Worksheet A-8-2, enter those overhead costs from Worksheet A-8 to the corresponding cost center.

*Column 3 – Total Physicians' Costs*

Total Physicians' costs are determined by adding column 1 and column 2. [This column will auto-populate.]

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

*Column 4 – Total Physician Inpatient and Outpatient Charges*

Enter the total charges related to physician inpatient and outpatient services from hospital records to the corresponding cost center.

*Column 5 – Cost-to-Charge Ratios*

For each cost center, a cost-to-charge ratio is calculated by dividing total physicians' costs in column 3 by total physician charges in column 4. [This column will auto-populate.]

*Column 6 – MassHealth FFS Physician Inpatient and Outpatient Charges*

Enter by cost center the total charges related to physician inpatient and outpatient services for MassHealth FFS patients from hospital records.

*Column 7 – MassHealth FFS Physician Inpatient and Outpatient Costs*

MassHealth FFS physician inpatient and outpatient costs are determined for each cost center by multiplying the MassHealth FFS inpatient and outpatient physician charges from column 6 by the cost-to-charge ratio from column 5. [This column will auto-populate.]

*Column 8 – Massachusetts Medicaid Managed Care Physician Inpatient and Outpatient Charges*

Enter the total charges related to physician inpatient and outpatient services for Massachusetts Medicaid managed care patients from hospital records.

*Column 9 – Massachusetts Medicaid Managed Care Physician Inpatient and Outpatient Costs*

Massachusetts Medicaid managed care physician inpatient and outpatient costs are determined for each cost center by multiplying the Massachusetts Medicaid managed care inpatient and outpatient physician charges from column 8 by the cost-to-charge ratio from column 5. [This column will auto-populate.]

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

*Column 10* – HSN and Uninsured Care Physician Inpatient and Outpatient Charges

From provider records, enter the charges related to physician inpatient and outpatient services for HSN and Uninsured Care patients as defined above.

*Column 11* – HSN and Uninsured Care Physician Inpatient and Outpatient Costs

HSN and Uninsured Care physician inpatient and outpatient costs are determined for each cost center by multiplying the HSN and Uninsured Care inpatient and outpatient physician charges from column 10 by the cost-to-charge ratio from column 5. [This column will auto-populate.]

*Column 12* – Total Massachusetts Medicaid Fee For Service Medicaid Managed Care and HSN and Uninsured Care Inpatient and Outpatient Physician Costs

Total Massachusetts Medicaid fee for service, managed care and HSN and Uninsured Care inpatient and outpatient physician costs are determined by adding column 7, column 9 and column 11.

Schedule E: Safety Net Health Care System (SNCHS) Expenditures

Pursuant to Section 49 (c) of the 1115 demonstration Special Terms and Conditions, expenditures for payments to providers is authorized under the safety net care pool to support uncompensated care for “Medicaid FFS, Medicaid managed care, and low-income uninsured individuals.” This Schedule E provides health care providers the opportunity to itemize such system expenditures for the Medicaid-eligible and uninsured population and includes the additional allowable costs outlined in the Development Tool approved by CMS on September 6, 2013 and any additional allowable costs described in the Cost Element table of this document.

*Column 1* – Total SNHCS Expenditures

Enter total safety net health care system expenditures for each line item.

*Column 2* – Medicaid-eligible / HSN and Uninsured Payer Mix Proportion

To determine the proportion of total system expenditures attributable to Medicaid-eligible and uninsured patients, first estimate the total charges for the year attributable to this group; next, estimate the total charges for the year attributable to all patients

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

served by the SNHCS. The ratio of these two numbers will be used to estimate the amount of system expenditures attributable to Medicaid-eligible and uninsured patients. Enter this ratio in column 2. Should an alternative ratio be more appropriate, enter that number, and then explain the basis for it in the Narrative Description section of Schedule E.

*Column 3 – Medicaid-eligible / HSN and Uninsured Share of System Expenditures*

Calculate the system expenditures attributable to Medicaid-eligible and uninsured patients by multiplying the total system expenditure in column 1 by the payer mix proportion in column 2. [This column will auto-populate.]

Schedule F: Medicaid and Uninsured Revenue

Note: Hospitals must ensure that any applicable revenues pertaining to Medicaid or uninsured costs allowed in Schedule E are captured in Schedule F and are treated as an offset to arrive at net uncompensated care costs.

Line Instructions:

Hospital and Clinic Revenue:

In lines 1-8, enter amounts paid for services provided by the hospital and any provider-based satellites, including hospital-licensed health centers.

Line 1 – Payer Medical Claims Revenue

For each column, enter in line 1 the total amount paid by the payer for medical claims. Do not include payments for that are not related to claims, such as pay-for-performance payments or supplemental payments. The amounts reported must reflect any post-payment reconciliations or recoupments, subject to the availability of that data.

Column 5 - Health Safety Net and Uninsured

In line 1, column 5, report the gross payments received from the HSN and Uninsured. Do not offset the amount of the HSN Assessment.

Line 2 – Pay for Performance / Incentive Payment Revenue

This revenue data is reported for informational purposes only. Payments that are not service payments for the provision of medical care are not offset against the eligible cost. Since following payments are not payments for the provision of medical care,

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

they are not offset against the eligible cost: SNCP grants and performance-based, incentive, and shared savings payments. These include performance-based and incentive-based payments and grants and awards both currently in existence and those that may be approved and implemented during future demonstration renewal periods.

Enter in line 2 any amounts paid by the payer for pay-for-performance or other incentive payments. The amount reported must also include any recoveries made by the payer for performance issue, such as retrospective performance penalties.

**Line 3-5 – Supplemental Payments**

Enter in lines 3-5 any amounts paid by the payer for supplemental payments. Specify the type of supplemental payment reported by modifying the title of the line. The total gross payment must be reported; do not offset any payment amount by any intergovernmental transfer amounts that may have been made by a related public entity.

**Line 6 – Medicare Revenue**

Enter in line 6 any payments amounts received by Medicare for services provided to patients who are eligible for both Medicare and the payer noted in the column.

**Line 7 – Third Party and Self Pay Revenue**

Enter in line 7 any payment amounts received by third parties, the patient, or the patient's guarantor for the cost-sharing or services not covered by the payer noted in the column.

**Line 8 – Other Revenue**

Enter in line 8 any additional revenue from the payer for the Medicaid-eligible and uninsured populations not included in lines 1-7. Specify the type of revenue by modifying the title of the line. Additional information may be provided in the Notes tab.

**Line 9 – Subtotal Hospital and Clinic**

Sum of lines 1-8. [This line will auto-populate.]

**Lines 10-15 Physician Revenue**

Using the same descriptions in the corresponding lines 1-8, report physician revenue related to the payers.

**Line 16 – Subtotal Physician Revenue**



**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

Sum of lines 10-15. [This line will auto-populate.]

Line 17 – Total Revenue.

Sum of lines 9 and 16. [This line will auto-populate.]

Column Instructions.

*Column 1* – Medicaid FFS Inpatient Revenue

Report in column 1, amounts paid by MassHealth for inpatient services provided to members enrolled in the MassHealth program, excluding those enrolled in MassHealth managed care programs.

*Column 2* – Medicaid FFS Outpatient Revenue

Report in column 2, amounts paid by MassHealth for outpatient services provided to members enrolled in the MassHealth program, excluding those enrolled in MassHealth managed care programs.

*Column 3* – Medicaid Managed Care Inpatient Revenue

Report in column 3, amounts paid by Medicaid Managed Care Organizations for inpatient services provided to members.

*Column 4* – Medicaid Managed Care Outpatient Revenue

Report in column 4, amounts paid by Medicaid Managed Care Organizations for outpatient services provided to members.

*Column 5* – HSN and Uninsured Inpatient and Outpatient Revenue

Report in column 5, amounts paid by the HSN and Uninsured individuals for inpatient and outpatient services provided. Report the gross payments received from the HSN. Do not offset the amount of the HSN Assessment.

*Column 6* – Total Revenue

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

Sum of columns 1 through 5. [This column will auto-populate.]

Schedule G: Notes

Providers may use Schedule G to provide additional information on the data reported.

**IV. Reconciliation**

Interim Reconciliation

Each provider's uncompensated care costs must be computed based on the provider's as-filed CMS 2552<sup>5</sup> cost report and Uniform Medicaid & Uncompensated Care Cost & Charge Report (UCCR) and for the actual service period. The CMS 2552 cost report is filed with the Medicare contractor five months after the close of the cost reporting period. The UCCR must be filed three months after the CMS 2552 is filed. For SNCP payments subject to the cost limit pursuant to STC 49(c), each provider's allowable Medicaid, uncompensated care, and uninsured costs must be reconciled against associated applicable payments received for the year for which the payments were made.

For hospitals whose accounting fiscal year aligns with the cost limit reporting fiscal year (Federal fiscal year), the Medicaid and uninsured costs will be reflected in the CMS 2552 and UCCR that is submitted for the accounting fiscal year. For acute hospitals whose accounting fiscal years do not align with the reporting fiscal year, the reporting year cost limit will be calculated by applying the appropriate percentage of the two contiguous CMS 2552 and UCCR cost reports that span the reporting fiscal year so that the Federal fiscal year will be represented in the cost limit calculation.

The Commonwealth must recover provider overpayments as it determines necessary based on its reconciliation calculations and availability of federal financial participation.

Specifically, if an overpayment exists, the Commonwealth must determine if the overpayment occurred due to Health Safety Net (HSN) Trust Fund payments or other SNCP payments, or from both payments. To the extent that the overpayment is a result of overpaid funds from the HSN Trust Fund, the Commonwealth must recover from the provider the amount overpaid to the provider from the HSN Trust Fund and credit that amount to the HSN Trust Fund. The HSN Trust Fund will redistribute such amounts to other providers as appropriate. To the extent that the overpayment is not

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<sup>5</sup> Community Based Detoxification Centers are the only provider type subject to the cost limit that does not submit the CMS 2552 cost report.

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

the result of HSN Trust Fund payments, the Commonwealth must recover from the provider the overpayment, and the Commonwealth must properly credit the federal share to the federal government.

The interim reconciliation described above must be performed and completed within twelve months after the filing of the Medicare cost report(s).

**Final Reconciliation**

Each provider's uncompensated care costs must be recomputed based on the provider's audited CMS 2552 cost report for the actual service period. These recomputed costs must be carried over to the UCCR. The CMS 2552 cost report is audited and settled by the Medicare contractor to determine final allowable costs and reimbursement amounts as recognized by Medicare. For SNCP payments subject to the cost limit pursuant to STC 49(c), each provider's allowable Medicaid, uncompensated care, and uninsured costs must be reconciled against associated applicable payments received for the year for which the payments were made. SNCP uncompensated care payments made to the provider for a cost limit reporting year cannot exceed the recomputed uncompensated care cost limit. If, at the end of the final reconciliation process, it is determined that expenditures claimed exceeded the individual provider's uncompensated care cost limit, thereby causing an overpayment, the Commonwealth must recoup the overpayment from the provider. Specifically, if an overpayment exists, the Commonwealth must determine if the overpayment occurred due to HSN Trust Fund payments or other SNCP payments, or from both payments. To the extent that the overpayment is a result of overpaid funds from the HSN Trust Fund, the Commonwealth must recover from the provider the amount overpaid to the provider from the HSN Trust Fund and credit that amount to the HSN Trust Fund. The HSN Trust Fund will redistribute such amounts to other providers as appropriate. To the extent that the overpayment is not the result of HSN Trust Fund payments, the Commonwealth must recover from the provider the overpayment, and the Commonwealth must properly credit the federal share to the federal government.

For hospitals whose accounting fiscal year aligns with the cost limit reporting fiscal year (Federal fiscal year), the Medicaid and uninsured costs will be reflected in the CMS 2552 and UCCR that is submitted for the accounting fiscal year. For acute hospitals whose accounting fiscal years do not align with the reporting fiscal year, the reporting year cost limit will be calculated by applying the appropriate percentage of the two contiguous CMS 2552 and UCCR cost reports that span the reporting fiscal year so that the Federal fiscal year will be represented in the cost limit calculation.

The Commonwealth must recover provider overpayments as it determines necessary based on its reconciliation calculations and availability of federal financial participation.

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

The final reconciliation described above must be performed and completed within twelve months after all final, audited CMS 2552 cost reports become available online.

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

**Institutions for Mental Diseases – Psychiatric Hospitals and Community Based  
Detoxification Centers (CBDCs) Protocol for Medicaid and Uncompensated Care  
Cost**

The Commonwealth will use the reports described below to collect data from these providers.

Psychiatric hospitals will fill out the CMS 2552 and UCCR, as required of other hospitals in the cost limit protocol. CBDCs are non-hospital human and social services contractors that do not file a CMS 2552 cost report; therefore, for the purposes of the protocol, the Commonwealth will use only the Massachusetts **Uniform Financial Statements and Independent Auditor’s Report (UFR)** to determine costs and revenues. The UFR is the set of financial statements and schedules required of human and social service contracting with state departments. For the calculation of provider-specific cost limits, psychiatric hospitals and CBDCs will fill out the necessary reports with the information that is relevant to the services they provide to the Medicaid-eligible and HSN and uninsured populations.

**Determination of Allowable Medicaid and Uninsured Costs**

- a. DSH Allowable Costs
  - i. Per STC 50(f), the Commonwealth will use the Medicaid DSH statutory, regulatory, and policy definitions of allowable psychiatric hospital services and allowable Medicaid and uninsured costs in determining hospital-specific cost limits in its cost protocols. To the extent that the determination of uncompensated care costs varies from the Medicaid DSH requirements, the process must be accounted for in this document.
  - ii. Pharmacy service costs are separately identified on the CMS 2552 10 cost report and are not recognized as an inpatient or outpatient hospital service. Pharmacy service costs that are not part of an inpatient or outpatient rate and are billed as pharmacy service and reimbursed as such are not considered eligible for inclusion in the hospital-specific uncompensated cost limit allowable under DSH. To the extent that the determination of allowable pharmacy costs varies from the Medicaid DSH requirements, the process must be accounted for in this document.
  - iii. Costs included must be for services that meet the federal definition and the approved Massachusetts State plan definition of “hospital services” for medical assistance. “Medical assistance” is defined as the cost of care and services “for individuals, and, with respect to physicians’ or dentists’ services, at the option of the State, to individuals [who are eligible]...” Section 1905 of the Act.

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

- b. Medicaid State Plan Allowable Costs
  - i. Massachusetts must use the same definition for all inpatient hospital, outpatient hospital, and physician services, clinic services, non-hospital services, etc. as described in its approved Medicaid State plan, and in accordance with Section 1905 of the Social Security Act and the regulations promulgated thereunder, to define allowable service costs provided by institutions for mental disease. Massachusetts identifies other service costs, subject to CMS approval, that are not included in the Medicaid state plan definitions to be included as allowable uncompensated care costs in this document (see Cost Element table).
    - 1. Inpatient psychiatric hospital services: Psychiatric treatment provided under the direction of a psychiatrist in a psychiatric inpatient hospital. Such services are as described in Section 1905 of the Social Security Act and the regulations promulgated thereunder.
    - 2. Outpatient psychiatric hospital services: Services provided to members on an outpatient basis in a psychiatric hospital. Such services are as described in Section 1905 of the Social Security Act and the regulations promulgated thereunder.
    - 3. Community Based Detoxification Center (CBDC): CBDCs are eligible to receive Safety Net Care Pool payments as Institutions for Mental Diseases (IMDs) under the section 1115 demonstration. Such services are as described in Section 1905 of the Social Security Act and the regulations promulgated thereunder.
      - a. Acute Inpatient Substance Abuse Treatment Services: Short-term medical treatment for substance withdrawal, individual medical assessment, evaluation, intervention, substance abuse counseling, and post detoxification referrals provided by an inpatient unit, either freestanding or hospital-based, licensed as an acute inpatient substance abuse treatment service by the Massachusetts Department of Public Health under its regulations at 105 CMR 160.000 and 161.000. These services are delivered in a three-tiered system consisting of Levels III-A through III-C that must conform with the standards and patient placement criteria issued and enforced by the Massachusetts Department of Public Health's Bureau of Substance Abuse Services.
      - b. Substance Abuse Outpatient Counseling Service: An outpatient counseling service that is a

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

rehabilitative treatment service for individuals and their families experiencing the dysfunctional effects of the use of substances.

- ii. 1115 Demonstration Population Expenditures: Costs incurred by psychiatric hospitals and CBDCs for providing IMD services to members eligible for Medicaid through the State plan and section 1115 demonstration will be counted as allowable costs. Allowable costs for psychiatric hospital services and CBDC services provided under the 1115 demonstration include service-related expenditures (please note that all services authorized under the section 1115 demonstration are subject to the requirements and limitations specified in the STCs). The list of allowable services is contained in the Cost Element table.

1. Diversionary Behavioral Health Services

- c. Medicaid Managed Care Costs: Costs incurred by IMDs for providing services to members enrolled in Medicaid managed care organizations including SCOs and ICOs, prepaid inpatient health plans, and any prepaid ambulatory health plans. Eligible costs are determined using the same methodology under this section.
- d. Other Allowable Costs, Approved 1915(c) Waivers. The list of allowable services in contained in the Cost Element table.
- e. Additional Allowable Costs – The list of allowable services is contained in the Cost Element table.

**I. Summary of 2552-10 Cost Report (Psychiatric Hospitals Only)**

Worksheet A: Reclassification and Adjustment of Trial Balance of Expenses

Worksheet A provides for recording the trial balance of expense accounts from your accounting books and records. It also provides for the necessary reclassifications and adjustments to certain accounts. Not included on Worksheet A are items that conflict with Medicare regulations, manuals, or instructions but which providers may wish to claim and contest.

The trial balance of expenses is broken down into the following categories to facilitate the transfer of costs to the various worksheets:

- 1) General service cost centers
- 2) Inpatient routine service cost centers
- 3) Ancillary service cost centers
- 4) Outpatient service cost centers
- 5) Other reimbursable cost centers
- 6) Special purpose cost centers
- 7) Other special purpose cost centers not previously identified

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

- 8) Costs applicable to nonreimbursable cost centers to which general service costs apply
- 9) Nonreimbursable cost center to accumulate the cost incurred by you for services related to the physicians' private practice

Worksheet B

Worksheet B allocates overhead (originally identified as general service cost centers) to all other cost centers, including the non-reimbursable costs identified in lines 96 through 100.

Cost finding is the process of recasting data derived from the accounts ordinarily kept by the provider to ascertain costs of the various types of services rendered; i.e., the allocation of the expenses of each general service cost center to those cost centers which receive the services. The CMS 2552 approved method of cost finding is recognized and outlined in 42 CFR 413.24 and is based on the accrual basis of accounting except where government institutions operate on a cash basis of accounting.

Worksheet C

Worksheet C computes the ratio of cost to charges (RCC) for inpatient services, ancillary services, outpatient services, and other reimbursable services. The total cost for each cost center is derived from Worksheet B after the overhead allocation, and the total charge for each cost center is determined from the provider's records. This RCC is used on Worksheet D, Worksheet D-3, Worksheet D-4, Worksheet H-3, and Worksheet J-2 to determine the program's share of ancillary service costs in accordance with 42 CFR 413.53. This worksheet is also needed to determine the adjusted total costs used on Worksheet D-1.

Worksheet D

This series of worksheets is where the total costs from Worksheet B are apportioned to different payer programs. Apportionment is the process by which a cost center's total cost is allocated to a specific payer or program or service type. Apportionment is used to arrive at Medicare hospital inpatient routine and ancillary cost and Medicare hospital outpatient cost, etc.

Worksheet D consists of the following five parts:

- 1) Part I: Apportionment of Inpatient Routine Service Capital Costs
- 2) Part II: Apportionment of Inpatient Ancillary Service Capital Costs
- 3) Part III: Apportionment of Inpatient Routine Service Other Pass Through Costs
- 4) Part IV: Apportionment of Inpatient/Outpatient Ancillary Service Other Pass Through Costs
- 5) Part V: Apportionment of Medical and Other Health Services Costs



**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

Worksheet D-1: All providers will complete this worksheet, which provides for the computation of hospital inpatient operating cost in accordance with 42 CFR 413.53 (determination of cost of services to beneficiaries), 42 CFR 413.40 (ceiling on rate of hospital cost increases), and 42 CFR 412.1 through 412.125 (prospective payment).

Worksheet D-2: Worksheet D-2 apportions the cost of services rendered by interns and residents across the following two parts:

- 1) Part I: Not in Approved Teaching Program. This part is used by the provider only if it has interns and residents that are not in an approved teaching program.
- 2) Part II: In an Approved Teaching Program (Title XVIII, Part B Inpatient Routine Costs Only). This part provides for reimbursement for inpatient routine services rendered by interns and residents in approved teaching programs to Medicaid beneficiaries.

Worksheet D-3: Worksheet D-3 apportions inpatient ancillary services.

Worksheet D-4: Worksheet D-4 computes organ acquisition costs and charges for hospitals that are certified transplant centers.

Worksheet D-5: Apportions cost for the services of teaching physicians.

Worksheet E

Worksheet E worksheets will be used to calculate Title XIX settlement for inpatient prospective payment system (IPPS) hospital services, medical and other health services.

NOTES:

For purposes of utilizing the CMS 2552 cost report to determine Medicare reimbursements, the term “as filed 2552 cost report” refers to the cost report filed on or before the last day of the fifth month following the close of the provider’s cost reporting period. The cost reporting period covers a 12-month period of operations based upon the provider’s accounting year.

**II. Uniform Medicaid & Uncompensated Care Cost & Charge Report (UCCR) (Psychiatric Hospitals Only)**

In relation to Medicaid reimbursement, the CMS 2552 report does not sufficiently capture costs for Massachusetts providers because costs cannot be allocated across other payers, nor are costs reimbursed through the CMS 2552 inclusive of those incurred for providing the types of services that support the Medicaid-eligible and

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

uninsured populations, such as those approved in this cost limit protocol as additional allowable costs.

The Commonwealth must use the CMS 2552<sup>6</sup> and Uniform Medicaid & Uncompensated Care Cost & Charge Report (UCCR) to determine Medicaid and uninsured costs. To supplement the Medicare 2552 cost report, hospitals subject to the cost protocol will file the UCCR to allocate allowable 2552 costs to Medicaid and uninsured services and, in accordance with the Cost Element table, recognize additional costs that are not otherwise reimbursed through the CMS 2552.

The UCCR report includes cost-center specific data by payer and its purpose is to capture uncompensated costs that safety net providers incur from supporting a large proportion of Medicaid-eligible and uninsured individuals. The UCCR also captures costs that are specifically allocated toward “funding required for the operation of the Safety Net Health Care System” on Schedule E, which was designed to reflect costs that are incurred disproportionately on behalf of Medicaid-eligible and uninsured patients (e.g., social, financial, and interpreter costs; unreimbursed costs for Dual Eligibles, etc. and other additional allowable costs approved in this cost limit protocol).

Overview

Psychiatric hospitals must submit cost, charge and patient day data via the UCCR, an electronic report developed by the Commonwealth, based on the CMS 2552, and currently used to record Medicaid and uncompensated care costs for certain safety net providers. For the Commonwealth’s use in calculating provider-specific uncompensated care cost limits, data submitted by the provider shall be based on information supplied on the hospital’s CMS 2552, as filed with and audited/settled by the Medicare fiscal intermediary, hospital records, and the UCCR.

NOTES:

The Medicaid-eligible population includes those individuals who are eligible for Medicaid but have private insurance; Medicaid FFS and Medicaid Managed Care, including individuals dually eligible for Medicaid and Medicare.

“Uninsured individuals” for whom uncompensated care costs are allowable includes the population for which HSN payments are made. Costs associated with Medicaid-eligible individuals who are uninsured for the service are allowable under this population, assuming the service meets all other criteria outlined in this protocol, including but not limited to being “medically necessary.”

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<sup>6</sup> Community Based Detoxification Centers are the only provider type subject to the cost limit that does not submit the CMS 2552 cost report.

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

Additionally, costs associated with the Medicaid-eligible population must not be duplicative of the uninsured individual costs.

The costs incurred for providing the services below are approved by CMS as additional allowable services not otherwise captured and/or allocated to the Medicaid-eligible and uninsured population through the CMS 2552 allocation method.

For the purposes of the UCCR, a Massachusetts Medicaid Managed Care Organization (otherwise referred to as “MMCO”) includes MCOs, Integrated Care Organizations (ICOs), Senior Care Organizations (SCOs), Programs of All-inclusive Care for the Elderly (PACE), and Prepaid Inpatient or Ambulatory Health Plan (including the behavioral health PIHP).

Cost Element	Inpatient Services	Outpatient Hospital Services	Chronic Disease and Rehab – Inpatient	Chronic Disease and Rehab – Outpatient	Psychiatric Inpatient Hospital	Psychiatric Outpatient Hospital	Substance Abuse Treatment – Inpatient	Substance Abuse Treatment – Outpatient
Professional component of provider-based physician costs, including contracted physician costs, which are not part of the inpatient hospital billing	X	X	X	X	X	X		
Provider component of provider-based physician costs reduced by Medicare reasonable compensation equivalency (RCE) limits, subject to applicable	X	X	X	X	X	X		

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

Cost Element	Inpatient Services	Outpatient Hospital Services	Chronic Disease and Rehab – Inpatient	Chronic Disease and Rehab – Outpatient	Psychiatric Inpatient Hospital	Psychiatric Outpatient Hospital	Substance Abuse Treatment – Inpatient	Substance Abuse Treatment – Outpatient
Medicare cost principles								
Administrative costs of the hospital's billing activities associated with physician services who are employees of the hospital billed and received by the hospital	X	X	X	X	X	X		
Patient and community education programs, excluding cost of marketing activities	X	X	X	X	X	X	X	X
Telemedicine services	X	X	X	X	X	X	X	X
Addiction Services	X	X	X	X	X	X		X
Community Psychiatric Support and Treatment		X		X		X		X
Medication Administration		X				X		
Vision Care		X						

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

Cost Element	Inpatient Services	Outpatient Hospital Services	Chronic Disease and Rehab – Inpatient	Chronic Disease and Rehab – Outpatient	Psychiatric Inpatient Hospital	Psychiatric Outpatient Hospital	Substance Abuse Treatment – Inpatient	Substance Abuse Treatment – Outpatient
Health care for the house bound and the homeless, family planning, and pre-natal, labor, and post-natal support for at risk pregnancies. CMS 255-10, Line 193		X						
Social, Financial, Interpreter, Coordinated Care and other services for Medicaid-eligible and uninsured patients	X	X	X	X	X	X	X	X
340b and other pharmacy costs		X						
Graduate Medical Education	X	X	X	X	X	X		
Outlier Day: Each day beyond 20 acute days, during a single admission, for which a member remains hospitalized at acute status	X							
Psychiatric Day		X				X		

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

Cost Element	Inpatient Services	Outpatient Hospital Services	Chronic Disease and Rehab – Inpatient	Chronic Disease and Rehab – Outpatient	Psychiatric Inpatient Hospital	Psychiatric Outpatient Hospital	Substance Abuse Treatment – Inpatient	Substance Abuse Treatment – Outpatient
Treatment Program Services								
Dental Services		X						
Intensive Early Intervention Services for Children with Autism Spectrum Disorder	X	X						
Diversionary Behavioral Health Services	X	X	X	X	X	X	X	X
Public Hospital Pensions and Retiree Benefits	X	X						

**UCCR Instructions**

Schedule A: Computation of MassHealth Fee-for-Service (FFS) Costs

*Column 1 – Reported Costs*

Enter costs from the hospital’s most recently filed Medicare cost report (CMS 2552) Worksheet B, Part 1, column 24. This column includes costs that have already been reclassified, adjusted and stepped down through the A and B worksheet series and includes costs related to interns and residents.

*Column 2 – Reclassification of Observation Costs and Inclusion of Post-Stepdown Costs*

Reclassify observation costs from Line 30 to Line 92. The observation costs are derived from the CMS-2552, Worksheet C, Part I, Column 5, Line 92.

Add post-step-down costs from Supplemental Worksheet B-2, Column 4, Lines 54, 60, 89 & 90, except costs related to interns and residents.

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

For line 30 (Adults and Pediatrics), include a decreasing adjustment, if applicable, for the swing bed costs reported on Worksheet D-1, Part I, line 26, and for the private room differential costs reported on Worksheet D-1, Part I, line 36.

*Column 3 – Total Costs*

Sum of costs from column 1 and column 2. [This column will auto-populate.]

*Column 4 – Charges*

Enter charges from the hospital's most recently filed Medicare cost report (CMS 2552) Worksheet C, Part I, column 8.

*Column 5 – Hospital Cost-to-Charge Ratios*

Calculate the cost-to-charge ratio for each cost center by dividing the total costs for each cost center from column 3 by the respective charges from column 4. [This column will auto-populate.]

*Column 6 – Total MassHealth Fee-for-Service Inpatient Charges:*

Enter from hospital records inpatient charges by cost center related to MassHealth Fee-for-Service (FFS) patients.

- MassHealth FFS Charges include only those charges for the following:
  - Medically necessary services as defined in 130 CMR 450.204;
  - MassHealth covered inpatient hospital services provided to MassHealth patients eligible pursuant to Titles XIX and XXI at the time of service delivery.
  
- MassHealth FFS Charges may not include:
  - Charges associated with services provided to MassHealth members where the service is covered by a Medicaid Managed Care Organization;
  - Charges associated with claims that have been final denied for payment by MassHealth;
  - Charges associated with state programs that are not Title XIX and Title XXI programs (e.g., the Children's Medical Security Plan);

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

- Charges associated with the professional component of hospital-based physician services.

*Column 7 – MassHealth FFS Inpatient Costs*

For Lines 50 through 117, calculate the MassHealth FFS inpatient costs by multiplying for each cost center the MassHealth FFS inpatient charges from column 8 by the respective hospital cost-to-charge ratios from column 5. [These lines will auto-populate.] For lines 30-46, costs are determined using a per diem methodology; these cells will automatically be populated after Schedule B (column 5) has been completed.

*Column 8 – MassHealth Fee-for-Service Outpatient Charges*

Enter from hospital records outpatient charges by cost center related to MassHealth Fee-for-Service (FFS) patients.

- MassHealth FFS Outpatient Charges include only those charges for the following:
  - Medically necessary services as defined in 130 CMR 450.204;
  - MassHealth covered outpatient hospital services provided to MassHealth patients eligible pursuant to Titles XIX and XXI at the time of service delivery.
- MassHealth FFS Outpatient Charges may not include:
  - Charges associated with services provided to MassHealth members where the service is covered by a Medicaid Managed Care Organization;
  - Charges associated with claims that have been final denied for payment by MassHealth;
  - Charges associated with state programs that are not Title XIX or Title XXI programs (e.g., the Children’s Medical Security Plan);
  - Charges associated with the professional component of hospital-based physician services.

*Column 9 – MassHealth Fee-for-Service Outpatient Costs*

MassHealth FFS outpatient costs are determined by multiplying the MassHealth outpatient charges for each cost center from column 8 by the respective hospital cost-to-charge ratios from column 5. [This column will auto-populate.]



**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

*Column 10* – Total MassHealth Fee-for-Service Inpatient and Outpatient Costs

Total MassHealth FFS costs are determined by adding the MassHealth inpatient costs from column 7 and the MassHealth outpatient costs from column 9. [This column will auto-populate.]

Schedule B: Computation of Inpatient Routine Cost Center Per Diems

For the purposes of completing Schedule B, patient days entered in Columns 2, 4, 6 and 8 must include only those days wherein a patient fully met, at the time of service, the criteria for the given category (FFS, MMCO, HSN and Uninsured Care), as set forth in the Instructions to Schedules A and C. The SNF, NF, and LTC cost centers must be removed from Schedule B, since these costs cannot be claimed as part of the hospital uncompensated care costs.

*Column 1* – Total Routine Cost Center Inpatient Costs

Enter total costs for each routine cost center as reported on UCCR Schedule A, Column 3, lines 30-46. [This column will auto-populate.]

*Column 2* – Total Inpatient Days

Enter total patient days for each routine cost center from CMS-2552 Worksheet S-3, Part 1, Column 8.

*Column 3* – Per Diem

Calculate the average cost per day (per diem) by dividing total costs for each cost center in column 1 by the respective total patient days in column 2. [This column will auto-populate.]

*Column 4* – MassHealth Fee-for-Service Inpatient Days

Enter total MassHealth FFS inpatient days for each routine cost center on lines 30-46 from provider records.

*Column 5* – Total MassHealth FFS Inpatient Costs

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

Calculate total FFS inpatient costs for each routine cost center by multiplying the days in column 4 by the per diem in column 3. [This column will auto-populate.]

*Column 6 – Medicaid Managed Care Inpatient Days*

Enter total Medicaid Managed Care inpatient days for each routine cost center on lines 30-46 from provider records.

*Column 7 – Total Medicaid Managed Care Inpatient Costs*

Calculate total MMCO inpatient costs for each routine cost center by multiplying the days in column 6 by the per diem in column 3. [This column will auto-populate.]

*Column 8 – HSN and Uninsured Care Inpatient Days*

Enter total HSN and Uninsured Care inpatient days for each routine cost center on lines 30-46 from provider records.

*Column 9 – Total HSN and Uninsured Care Inpatient Costs*

Calculate total HSN and Uninsured Care inpatient costs for each routine cost center by multiplying the days in column 8 by the per diem in column 3. [This column will auto-populate.]

Schedule C: Computation of Massachusetts Medicaid Managed Care (MMCO) and HSN and Uninsured Costs

For the purposes of completing Schedule C:

- Massachusetts Medicaid Managed Care Charges include only those charges for the following:
  - Medically necessary services as defined in 130 CMR 450.204;
  - MassHealth covered inpatient and outpatient hospital services provided to MassHealth patients eligible pursuant to Titles XIX and XXI and enrolled in a MassHealth contracting MCO, SCO, PACE, PIHP and PAHP (MMCO) at the time of service delivery.
  
- Medicaid Managed Care Charges may not include:

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

- Charges associated with services provided to MassHealth members where the service is covered under MassHealth Fee-for-Service, including the Primary Care Clinician program;
  - Charges associated with claims that have been final denied for payment by the MMCO;
  - Charges associated with state programs that are not Title XIX and Title XXI programs (e.g., the Children's Medical Security Plan);
  - Charges reported as HSN and Uninsured Care (below).
- HSN and Uninsured Care Inpatient and Outpatient Charges are defined as those charges associated with care provided by hospitals for medically necessary services, including services reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity provided to:
    - Individuals with no health insurance coverage;
    - Low-Income Patients (under state regulation 114.6 CMR 12.03 (3) or (4) or its successor regulation) with no health insurance coverage;
    - Low-Income Patients (under state regulation 114.6 CMR 12.03 (3) or (4) or its successor regulation) whose public or private health insurance plan does not cover the cost of the particular service (excluding unpaid coinsurance and/or deductible amounts); or
    - Medicaid-eligible patients whose medical service is not paid by MassHealth or the Massachusetts Medicaid Managed Care Organizations, SCO, ICO, PACE, PIHP or PAHP;
  - HSN and Uninsured Care Charges, for the purpose of Schedule C of the UCCR, shall exclude charges associated with:
    - Professional component of physician charges;
    - Overhead charges related to physician services.

*Column 1 – Hospital Cost-to-Charge Ratios*

Enter the hospital cost-to-charge ratio for each cost center from Schedule A: MassHealth Fee-for-Service (FFS) Costs column 5. [This column will auto-populate.]

*Column 2 – Massachusetts Medicaid Managed Care Inpatient Charges*

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

Enter from hospital records inpatient charges, by cost center, related to Massachusetts Medicaid managed care patients.

*Column 3 – Massachusetts Medicaid Managed Care Inpatient Costs*

Massachusetts Medicaid managed care inpatient costs are determined by multiplying the Massachusetts Medicaid managed care inpatient charges for each cost center from column 2 by the respective hospital cost-to-charge ratios from column 1. However, for lines 30-46, costs are determined using a per diem methodology via Schedule B. [This column will auto-populate.]

*Column 4 – Massachusetts Medicaid Managed Care Outpatient Charges*

Enter from hospital records outpatient charges, by cost center, related to Massachusetts Medicaid managed care patients.

*Column 5 – Massachusetts Medicaid Managed Care Outpatient Costs*

Massachusetts Medicaid managed care outpatient costs are determined by multiplying the Massachusetts Medicaid managed care outpatient charges for each cost center from column 4 by the respective hospital cost-to-charge ratios from column 1.

*Column 6 – Total Massachusetts Medicaid managed care Inpatient and Outpatient Costs*

Total Massachusetts Medicaid managed care inpatient and outpatient costs are determined by adding the Massachusetts Medicaid managed care inpatient costs from column 3 and the Massachusetts Medicaid managed care outpatient costs from column 5.

*Column 7 – HSN and Uninsured Care Inpatient Charges*

Enter from hospital records inpatient charges, by cost center, related to HSN and Uninsured Care patients.

*Column 8 – HSN and Uninsured Care Inpatient Costs*

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

For Lines 50 through 117, HSN and Uninsured Care inpatient costs are determined by multiplying the HSN and Uninsured Care inpatient charges for each cost center from column 7 by the respective hospital cost-to-charge ratios from column 1; for lines 30-46, costs are determined using a per diem methodology via Schedule B. [This column will auto-populate through line 94.]

*Column 9* – HSN and Uninsured Care Outpatient Charges

Enter from the hospital records outpatient charges by cost center related to HSN and Uninsured patients.

*Column 10* – HSN and Uninsured Care Outpatient Costs

HSN and Uninsured Care outpatient costs are determined by multiplying the HSN and Uninsured Care outpatient charges for each cost center from column 9 by the respective hospital cost-to-charge ratios from column 1.

*Column 11* – Total HSN and Uninsured Care Costs

Total uncompensated care inpatient and outpatient costs are determined by adding the HSN and Uninsured Care inpatient costs from column 8 and the HSN and Uninsured Care outpatient costs from column 10.

Schedule D: Computation of Uncompensated Care Physician Costs

For purposes of completing Schedule D:

Uncompensated Physician Costs are limited to those charges incurred by hospital-based physicians for professional services.

- MassHealth FFS Inpatient and Outpatient Charges include only those charges for the following:
  - Medically necessary services as defined in 130 CMR 450.204;
  - MassHealth covered hospital-based physician professional services provided to MassHealth patients eligible pursuant to Titles XIX and XXI at the time of service delivery.
  - Charges associated with the professional component of hospital-based physicians services.

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

- MassHealth FFS Hospital-Based Physician Professional Charges may not include:
  - Charges associated with services provided to MassHealth members where the service is covered by a Medicaid Managed Care Organization;
  - Charges associated with claims that have been final denied for payment by MassHealth;
  - Charges associated with state programs that are not Title XIX and Title XXI programs (e.g., the Children's Medical Security Plan);
  
- Massachusetts Medicaid Managed Care Charges include only those charges for the following:
  - Medically necessary services as defined in 130 CMR 450.204;
  - MassHealth covered hospital-based physician professional services provided to MassHealth patients eligible pursuant to Titles XIX and XXI and enrolled in a MassHealth contracting MCO, SCO, PACE, PIHP and PAHP (MMCO) at the time of service delivery;
  - Charges associated with professional component of hospital-based physician services.
  
- Medicaid Managed Care Charges may not include:
  - Charges associated with services provided to MassHealth members where the service is covered under MassHealth Fee-for-Service, including the Primary Care Clinician program;
  - Charges associated with claims that have been final denied for payment by the MMCO;
  - Charges associated with state programs that are not Title XIX and Title XXI programs (e.g., the Children's Medical Security Plan);
  - Charges reported as HSN and Uninsured Care (below).
  
- HSN and Uninsured Care Physician Charges are defined as those physician charges associated with care provided for medically necessary services, including services reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity provided to:
  - Individuals with no health insurance coverage;
  - Low-Income Patients (under state regulation 114.6 CMR 12.03 (3) or (4) or its successor regulation) with no health insurance coverage;
  - Low-Income Patients (under state regulation 114.6 CMR 12.03 (3) or (4) or its successor regulation) whose public or private health

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

- insurance plan does not cover the cost of the particular service (excluding unpaid coinsurance and/or deductible amounts); or
- Medicaid-eligible patients whose medical service is not paid by MassHealth or the Massachusetts Medicaid Managed Care Organizations, SCO, ICO, PACE, PIHP or PAHP;

*Column 1* – Professional Component of Physicians’ Costs

The professional component of physicians’ costs come from the hospital’s most recently filed Medicare cost report (CMS 2552) Worksheet A-8-2, column 4.

*Column 2* – Overhead Costs Related to Physicians’ Services

If the overhead costs related to physicians’ services were adjusted out of the physicians’ costs entered on Worksheet A-8-2, enter those overhead costs from Worksheet A-8 to the corresponding cost center.

*Column 3* – Total Physicians’ Costs

Total Physicians’ costs are determined by adding column 1 and column 2. [This column will auto-populate.]

*Column 4* – Total Physician Inpatient and Outpatient Charges

Enter the total charges related to physician inpatient and outpatient services from hospital records to the corresponding cost center.

*Column 5* – Cost-to-Charge Ratios

For each cost center, a cost-to-charge ratio is calculated by dividing total physicians’ costs in column 3 by total physician charges in column 4. [This column will auto-populate.]

*Column 6* – MassHealth FFS Physician Inpatient and Outpatient Charges

Enter by cost center the total charges related to physician inpatient and outpatient services for MassHealth FFS patients from hospital records.

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

*Column 7 – MassHealth FFS Physician Inpatient and Outpatient Costs*

MassHealth FFS physician inpatient and outpatient costs are determined for each cost center by multiplying the MassHealth FFS inpatient and outpatient physician charges from column 6 by the cost-to-charge ratio from column 5. [This column will auto-populate.]

*Column 8 – Massachusetts Medicaid Managed Care Physician Inpatient and Outpatient Charges*

Enter the total charges related to physician inpatient and outpatient services for Massachusetts Medicaid managed care patients from hospital records.

*Column 9 – Massachusetts Medicaid Managed Care Physician Inpatient and Outpatient Costs*

Massachusetts Medicaid managed care physician inpatient and outpatient costs are determined for each cost center by multiplying the Massachusetts Medicaid managed care inpatient and outpatient physician charges from column 8 by the cost-to-charge ratio from column 5. [This column will auto-populate.]

*Column 10 – HSN and Uninsured Care Physician Inpatient and Outpatient Charges*

From provider records, enter the charges related to physician inpatient and outpatient services for HSN and Uninsured Care patients as defined above.

*Column 11 – HSN and Uninsured Care Physician Inpatient and Outpatient Costs*

HSN and Uninsured Care physician inpatient and outpatient costs are determined for each cost center by multiplying the HSN and Uninsured Care inpatient and outpatient physician charges from column 10 by the cost-to-charge ratio from column 5. [This column will auto-populate.]

*Column 12 – Total Massachusetts Medicaid Fee-For-Service, Medicaid Managed Care and HSN and Uninsured Care Inpatient and Outpatient Physician Costs*



**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

Total Massachusetts Medicaid Fee-For-Service, managed care and HSN and Uninsured Care inpatient and outpatient physician costs are determined by adding column 9 and column 11.

Schedule E: Safety Net Health Care System (SNCHS) Expenditures

Pursuant to Section 49 (c) of the 1115 demonstration Special Terms and Conditions, expenditures for payments to providers is authorized under the safety net care pool to support uncompensated care for “Medicaid FFS, Medicaid managed care, and low-income uninsured individuals.” This Schedule E provides health care providers the opportunity to itemize such system expenditures for the Medicaid-eligible and uninsured population and includes the additional allowable costs outlined in the Development Tool approved by CMS on September 6, 2013 and any additional allowable costs described in the Cost Element table of this document. .

*Column 1* – Total System Expenditures

Enter total safety net health care system expenditures for each line item.

*Column 2* – Medicaid-eligible / HSN and Uninsured Payer Mix Proportion

To determine the proportion of total system expenditures attributable to Medicaid-eligible and uninsured patients, first estimate the total charges for the year attributable to this group; next, estimate the total charges for the year attributable to all patients served by the SNHCS. The ratio of these two numbers will be used to estimate the amount of system expenditures attributable to Medicaid-eligible and uninsured patients. Enter this ratio in column 2. Should an alternative ratio be more appropriate, enter that number, and then explain the basis for it in the Narrative Description section of Schedule E.

*Column 3* – Medicaid-eligible / HSN and Uninsured Share of System Expenditures

Calculate the system expenditures attributable to Medicaid-eligible and uninsured patients by multiplying the total system expenditure in column 1 by the payer mix proportion in column 2. [This column will auto-populate.]

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

Schedule F: Medicaid and Uninsured Revenue

Note: Hospitals must ensure that any applicable revenues pertaining to Medicaid or uninsured costs allowed in Schedule E are captured in Schedule F and are treated as an offset to arrive at net uncompensated care costs.

Line Instructions:

Hospital and Clinic Revenue:

In lines 1-8, enter amounts paid for services provided by the hospital and any provider-based satellites, including hospital-licensed health centers.

Line 1 – Payer Medical Claims Revenue

For each column, enter in line 1 the total amount paid by the payer for medical claims. Do not include payments for that are not related to claims, such as pay-for-performance payments or supplemental payments. The amounts reported must reflect any post-payment reconciliations or recoupments, subject to the availability of that data.

Column 5 - Health Safety Net and Uninsured

In line 1, column 5, report the gross payments received from the HSN and Uninsured. Do not offset the amount of the HSN Assessment.

Line 2 – Pay-for-Performance / Incentive Payment Revenue

This revenue data is reported for informational purposes only. Payments that are not service payments for the provision of medical care are not offset against the eligible cost. Since the following payments are not payments for the provision of medical care, they are not offset against the eligible cost: SNCP grants and performance-based, incentive, and shared savings payments. These include performance-based and incentive-based payments and grants and awards both currently in existence and those that may be approved and implemented during future demonstration renewal periods.

Enter in line 2 any amounts paid by the payer for pay-for-performance or other incentive payments. The amount reported must also include any recoveries made by the payer for performance issue, such as retrospective performance penalties.

Line 3-5 – Supplemental Payments

Enter in lines 3-5 any amounts paid by the payer for supplemental payments. Specify the type of supplemental payment reported by modifying the title of the line. The total

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

gross payment must be reported; do not offset any payment amount by any intergovernmental transfer amounts that may have been made by a related public entity.

**Line 6 – Medicare Revenue**

Enter in line 6 any payments amounts received by Medicare for services provided to patients who are eligible for both Medicare and the payer noted in the column.

**Line 7 – Third Party and Self Pay Revenue**

Enter in line 7 any payment amounts received by third parties, the patient, or the patient's guarantor for the cost-sharing or services not covered by the payer noted in the column.

**Line 8 – Other Revenue**

Enter in line 8 any additional revenue from the payer for the Medicaid-eligible and uninsured populations not included in lines 1-7. Specify the type of revenue by modifying the title of the line. Additional information may be provided in the Notes tab.

**Line 9 – Subtotal Hospital and Clinic**

Sum of lines 1-8. [This line will auto-populate.]

**Lines 10-15 Physician Revenue**

Using the same descriptions in the corresponding lines 1-8, report physician revenue related to the payers.

**Line 16 – Subtotal Physician Revenue**

Sum of lines 10-15. [This line will auto-populate.]

**Line 17 – Total Revenue.**

Sum of lines 9 and 16. [This line will auto-populate.]

Column Instructions.

*Column 1 – Medicaid FFS Inpatient Revenue*

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

Report in column 1, amounts paid by MassHealth for inpatient services provided to members enrolled in the MassHealth program, excluding those enrolled in MassHealth managed care programs.

*Column 2 – Medicaid FFS Outpatient Revenue*

Report in column 2, amounts paid by MassHealth for outpatient services provided to members enrolled in the MassHealth program, excluding those enrolled in MassHealth managed care programs.

*Column 3 – Medicaid Managed Care Inpatient Revenue*

Report in column 3, amounts paid by Medicaid Managed Care Organizations for inpatient services provided to members.

*Column 4 – Medicaid Managed Care Outpatient Revenue*

Report in column 4, amounts paid by Medicaid Managed Care Organizations for outpatient services provided to members.

*Column 5 – HSN and Uninsured Inpatient and Outpatient Revenue*

Report in column 5, amounts paid by the HSN and Uninsured individuals for inpatient and outpatient services provided. Report the gross payments received from the HSN. Do not offset the amount of the HSN Assessment.

*Column 6 – Total Revenue*

Sum of columns 1 through 5. [This column will auto-populate.]

Schedule G: Notes

Providers may use Schedule G to provide additional information on the data reported.

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

**III. Uniform Financial Report (UFR)**

CBDCs are entities that provide health care services for substance abuse that contract with the MassHealth agency, Medicaid Managed Care Entities and the Bureau of Substance Abuse Services, the latter providing services to the uninsured. Each CBDC is licensed by the Bureau of Substance Abuse Services under the requirements set forth in 105 CMR 164.000. Because CBDCs are not a hospital, they do not fill out the Medicare CMS-2552 cost report and instead fill out the Uniform Financial Report (UFR).

UFR reports are filed with the Massachusetts Operational Services Division (OSD) on an annual basis. This report captures administration and support costs, as defined in 808 CMR 1.00, which includes expenditures for the overall direction of the organization, e.g., general record keeping, budgeting, etc., but also the salaries and expenses of the organization's staff. The report will also capture expenditures for health care services, as defined in M.G.L. c. 118 § 2 (b), the pricing of which is set by the Center for Health Information and Analysis

The CBDCs are required to keep necessary data on file to satisfy the UFR reporting requirements, and books and records must be maintained in accordance with generally accepted accounting principles set forth by the American Institute of Certified Public Accountants (AICPA).

The UFR must be submitted on or before the 15<sup>th</sup> day of the fifth month after the end of the contractor's fiscal year.

The UFR reports the following data elements:

1. Net Assets
2. Total Current Assets
3. Total Assets
4. Total Current Liabilities
5. Total Liabilities
6. Total Liabilities and Net Assets
7. Total Revenue, Gains, and Other Support
8. Total Expenses and Losses
9. Indirect / Direct Method
10. Cash from Operating Activities
11. Cash from Investing Activities
12. Cash from Financing Activities
13. Total Expenses – Programs
14. Total Expenses – Supporting Services
15. Surplus Percentage
16. Surplus Retention Liability

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

The UFR allows for revenue to be reported from Medicaid Direct Payments, Medicaid Massachusetts behavioral Health Partnership (MBHP) Subcontracts, Department of Mental Health, Department of Public Health, and other human and social service agencies.

The CBDC's program expense is broken down by provider type for Psychiatric Day Treatment and Substance Abuse Class Rate Services, including:

1. Psychiatrist
2. N.P., Psych N., N.A., R.N.-Masters
3. R.N.-Non Masters
4. L.P.N.
5. Occupational Therapist
6. Psychologist – Doctorate
7. Clinician (formerly Psych. Masters)
8. Social Worker – L.I.C.S.W.
9. Social Worker – L.C.S.W., L.S.W.
10. Licensed Counselor
11. Cert. Voc. Rehab. Counselor
12. Counselor
13. Case Worker/Manager – Masters
14. Case Worker/Manager
15. Direct Care/Program Staff Supervisor
16. Direct Care/Program Staff

**Per unit cost from UFR.** The provider will calculate a per unit cost from the UFR for inpatient detoxification programs, who do not submit the Medicare 2552 cost report, by dividing the total reimbursable program expense (Schedule B line 53E) by line 6SS (number of service units delivered). The per diem cost will be reported by the CBDC on the CBDC Protocol Form.

**Allowable Costs**

- i. From the MMIS paid claims database, the State will obtain the number of units of care, including administrative units, provided to all Medicaid patients.
- ii. Providers will be required to file a supplemental schedule with EOHHS that reports the number of units, days of care, including administrative days, for services provided to Medicaid MCO and other uninsured patients.<sup>7</sup>
- iii. The state will calculate costs by multiplying the per unit cost with the number of MassHealth, Medicaid MCO, and uninsured units described above.

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<sup>7</sup> This is not currently available on the UFR report.

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

**Payments**

- i. From the MMIS paid claims database, the state will obtain payments made to programs for services, including administrative days, provided to MassHealth patients.
- ii. Providers will be required to file a supplemental schedule with EOHHS reporting payments received from all sources for services provided to Medicaid MCO and uninsured patients.

**Determination of Provider-Specific SNCP Limit for CBDCs**

The State will calculate a provider-specific SNCP limit for each CBDC as by subtracting all applicable payments from the allowable costs

**IV. Reconciliation**

Interim Reconciliation for CMS 2552 and UCCR Methods

Each provider's uncompensated care costs must be computed based on the provider's as-filed CMS 2552<sup>8</sup> cost report and Uniform Medicaid & Uncompensated Care Cost & Charge Report (UCCR) and for the actual service period. The CMS 2552 cost report is filed with the Medicare contractor five months after the close of the cost reporting period. The UCCR must be filed three after months after the CMS 2552 is filed. For SNCP payments subject to the cost limit pursuant to STC 49(c), each provider's allowable Medicaid, uncompensated care, and uninsured costs must be reconciled against associated applicable payments received for the year for which the payments were made.

For hospitals whose accounting fiscal year aligns with the cost limit reporting fiscal year (Federal fiscal year), the Medicaid and uninsured costs will be reflected in the CMS 2552 and UCCR that is submitted for the accounting fiscal year. For acute hospitals whose accounting fiscal years do not align with the reporting fiscal year, the reporting year cost limit will be calculated by applying the appropriate percentage of the two contiguous CMS 2552 and UCCR cost reports that span the reporting fiscal year so that the Federal fiscal year will be represented in the cost limit calculation.

The Commonwealth must recover provider overpayments as it determines necessary based on its reconciliation calculations and availability of federal financial participation.

If an overpayment exists, the Commonwealth must determine if the overpayment occurred due to Health Safety Net (HSN) Trust Fund payments or other SNCP payments, or from both payments. To the extent that the overpayment is a result of

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<sup>8</sup> Community Based Detoxification Centers are the only provider type subject to the cost limit that does not submit the CMS 2552 cost report.

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

overpaid funds from the HSN Trust Fund, the Commonwealth must recover from the provider the amount overpaid to the provider from the HSN Trust Fund and credit that amount to the HSN Trust Fund. The HSN Trust Fund will redistribute such amounts to other providers as appropriate. To the extent that the overpayment is not the result of HSN Trust Fund payments, the Commonwealth must recover from the provider the overpayment, and the Commonwealth must properly credit the federal share to the federal government.

The interim reconciliation described above must be performed and completed within twelve months after the filing of the UCCR(s).

Final Reconciliation for CMS 2552 and UCCR Methods

Each provider's uncompensated care costs must be recomputed based on the provider's audited CMS 2552 cost report for the actual service period. These recomputed costs must be carried over to the UCCR. The CMS 2552 cost report is audited and settled by the Medicare contractor to determine final allowable costs and reimbursement amounts as recognized by Medicare. For SNCP payments subject to the cost limit pursuant to STC 49(c), each provider's allowable Medicaid, uncompensated care, and uninsured costs must be reconciled against associated applicable payments received for the year for which the payments were made. SNCP uncompensated care payments made to the provider for a cost limit reporting year cannot exceed the recomputed uncompensated care cost limit. If, at the end of the final reconciliation process, it is determined that expenditures claimed exceeded the individual provider's uncompensated care cost limit, thereby causing an overpayment, the Commonwealth must recoup the overpayment from the provider. Specifically, if an overpayment exists, the Commonwealth must determine if the overpayment occurred due to HSN Trust Fund payments or other SNCP payments, or from both payments. To the extent that the overpayment is a result of overpaid funds from the HSN Trust Fund, the Commonwealth must recover from the provider the amount overpaid to the provider from the HSN Trust Fund and credit that amount to the HSN Trust Fund. The HSN Trust Fund will redistribute such amounts to other providers as appropriate. To the extent that the overpayment is not the result of HSN Trust Fund payments, the Commonwealth must recover from the provider the overpayment, and the Commonwealth must properly credit the federal share to the federal government.

For hospitals whose accounting fiscal year aligns with the cost limit reporting fiscal year (Federal fiscal year), the Medicaid and uninsured costs will be reflected in the CMS 2552 and UCCR that is submitted for the accounting fiscal year. For acute hospitals whose accounting fiscal years do not align with the reporting fiscal year, the reporting year cost limit will be calculated by applying the appropriate percentage of the two contiguous CMS 2552 and UCCR cost reports that span the reporting fiscal year so that the Federal fiscal year will be represented in the cost limit calculation.



**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

The Commonwealth must recover provider overpayments as it determines necessary based on its reconciliation calculations and availability of federal financial participation.

The final reconciliation described above must be performed and completed within twelve months after all final, audited CMS 2552 cost reports become available online.

**Interim Reconciliation for UFR Method**

Each provider's uncompensated care costs must be computed based on the provider's as-filed Uniform Financial Report (UFR) and for the actual service period. The UFR is filed five months after the close of the cost reporting period. SNCP uncompensated care payments made to the provider for a cost limit reporting year cannot exceed the recomputed uncompensated care cost limit. Per unit cost will be derived from the as-filed UFR; and Medicaid and uninsured units of service and payments will be derived from the latest available auditable data for the service period. If, at the end of the interim reconciliation process, it is determined that expenditures claimed exceeded the individual provider's uncompensated care cost limit, the overpayment will be recouped from the provider, and the federal share will be properly credited to the federal government.

A provider's uncompensated care cost limit is determined for the twelve month period in each cost limit reporting year. For providers whose accounting fiscal year aligns with the cost limit reporting fiscal year (Federal fiscal year), the Medicaid and uninsured costs will be reflected in UFR and supplemental schedule that is submitted for the accounting fiscal year. For providers whose accounting fiscal years do not align with the reporting fiscal year, the reporting year cost limit will be calculated by applying the appropriate percentage of the two contiguous UFR and supplemental schedule reports that span the reporting fiscal year so that the Federal fiscal year will be represented in the cost limit calculation.

The interim reconciliation described above will be performed and completed within twelve months after the filing of the provider's UFR.

**Final Reconciliation for the UFR Method**

Each provider's uncompensated care costs must be recomputed based on the provider's audited UFR for the actual service period. The UFR is audited and settled by the Commonwealth to determine final allowable costs and reimbursement amounts as recognized by the Commonwealth based on this cost limit protocol. SNCP uncompensated care payments made to the provider for a cost limit reporting year cannot exceed the recomputed uncompensated care cost limit. Per unit cost will be derived from the as-filed UFR; and Medicaid and uninsured units of service and payments will be derived from the latest available auditable data for the service

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

period. If, at the end of the final reconciliation process, it is determined that expenditures claimed exceeded the individual provider's uncompensated care cost limit, the overpayment will be recouped from the provider, and the federal share will be properly credited to the federal government. Settlement of any over- or underpayment to a provider will be treated as a separate transaction rather an adjustment to the following year's interim payment.

A provider's uncompensated care cost limit is determined for the twelve month period in each cost limit reporting year. For providers whose accounting fiscal year aligns with the cost limit reporting fiscal year (Federal fiscal year), the Medicaid and uninsured costs will be reflected in UFR and supplemental schedule that is submitted for the accounting fiscal year. For providers whose accounting fiscal years do not align with the reporting fiscal year, the reporting year cost limit will be calculated by applying the appropriate percentage of the two contiguous UFR and supplemental schedule reports that span the reporting fiscal year so that the Federal fiscal year will be represented in the cost limit calculation.

The final reconciliation described above will be performed and completed within twelve months after the audited provider UFR is made available.

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

Introduction

This cost limit protocol will meet the required protocol specifications pursuant to Massachusetts 1115 Demonstration Special Terms and Conditions (STC) 50(f). According to this protocol:

- 1) The cost limit must be calculated on a provider-specific basis.
- 2) Only the providers receiving SNCP payments for uncompensated care pursuant to STC 49(c) will be subject to the protocol.
  - a. All Medicaid Fee-for-Service payments for services and managed care payments, including any supplemental or enhanced Medicaid payments made under the State plan <sup>1</sup>, SNCP payments subject to the Provider Cap pursuant to STC 50(c), and any other revenue received by the providers by or on behalf of Medicaid-eligible individuals or uninsured patients are offset against the eligible cost. Payments that are not service payments for the provision of medical care are not offset against the eligible cost. Since the following payments are not payments for the provision of medical care, they are not offset against the eligible cost: SNCP grants and performance-based, incentive, and shared savings payments. These include performance- and incentive-based payments and grants and awards both currently in existence and those that may be implemented during future demonstration renewal periods, such as those listed below.
  - b. Performance- and incentive-based payments, including but not limited to:
    - i. Pay-for-performance payments made under the Medicaid state plan;
    - ii. Quality incentive payments associated with an alternative payment arrangement authorized under the Medicaid state plan or the section 1115 demonstration;
    - iii. Delivery System Transformation Initiative payments made under the 1115 demonstration;
    - iv. Patient Centered Medical Home Initiative payments, including care management and coordination payments, made under the 1115 demonstration;
    - v. Shared savings and other risk-based payments under an alternative payment arrangement (e.g., Primary Care Payment Reform, subject to CMS approval), authorized under the Medicaid state plan or the section 1115 demonstration;

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<sup>1</sup> State Plan supplemental payments include, but may not be limited to, Essential MassHealth Hospital Payments, Freestanding Pediatric Acute Hospital Payments, Acute Hospitals with High Medicaid Discharges Payments, and Infant and Pediatric Outlier Payment Adjustments. Safety Net Care Pool supplemental payments under the 1115 demonstration include Public Service Hospital Payments.

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

- vi. Medicaid EHR incentive payments, including eligible provider and hospital Electronic Health Record (EHR) incentive payments, made in accordance with the CMS-approved state Medicaid Plan and CMS regulations.
  
- c. Grants and awards:
  - i. Infrastructure and Capacity Building grants and any other grants or awards awarded by the Commonwealth of Massachusetts or any of its agencies;
  - ii. Any grants or awards through the CMS Innovation Center or other federal programs;
  - iii. Any grants or awards by a private foundation or other entity.

**Acute Inpatient and Outpatient Hospital Protocol for Medicaid and Uncompensated Care Cost**

Determination of Allowable Medicaid and Uninsured Costs

- a. Disproportionate Share Hospital (DSH) Allowable Costs
  - i. Per STC 50(f), the Commonwealth will use the Medicaid DSH statutory, regulatory, and policy definitions of allowable inpatient hospital and outpatient hospital services and allowable Medicaid and uninsured costs in determining hospital-specific cost limits in its cost protocols. To the extent that the determination of uncompensated care costs varies from the Medicaid DSH requirements, the process must be accounted for in this document.
  - ii. Allowable pharmacy costs include the cost of drugs and pharmacy supplies requested by patient care departments and drugs charged to patients. Pharmacy service costs that are not part of an inpatient or outpatient service, such as retail pharmacy costs, are not considered eligible for inclusion in the hospital-specific uncompensated cost limit allowable under DSH. To the extent that the determination of allowable pharmacy costs varies from the Medicaid DSH requirements, the process must be accounted for in this document.
  - iii. Costs included must be for services that meet the federal definition and the approved Massachusetts State plan definition of “hospital services” for medical assistance. “Medical assistance” is defined as the cost of care and services “for individuals, and, with respect to physicians’ or dentists’ services, at the option of the State, to individuals [who are eligible]...” per Section 1905 of the Act.
- b. Medicaid State Plan Allowable Costs
  - i. Massachusetts will use the same definition for all inpatient hospital, outpatient hospital, and physician services, clinic services, non-hospital services, etc. as described in its approved Medicaid State plan,

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

and in accordance with Section 1905 of the Social Security Act and the regulations promulgated thereunder, to define allowable service costs provided by acute inpatient and outpatient hospitals. Massachusetts identifies other service costs, subject to CMS approval, that are not included in the Medicaid state plan definitions to be included as allowable uncompensated care costs in this document (see Cost Element table).

1. Inpatient acute hospital services: Medical services provided to a member admitted to an acute inpatient hospital. Such services are as described in Section 1905 of the Social Security Act and the regulations promulgated thereunder.
  2. Outpatient acute hospital services: Outpatient Hospital Services include medical services provided to a member in a hospital outpatient department. Such services include, but are not limited to, emergency services, primary-care services, observation services, ancillary services, and day-surgery services. Outpatient Services include medical services provided to a member in an outpatient setting including but not limited to hospital outpatient departments, hospital-licensed health centers or other hospital satellite clinics, hospital-based physicians' offices, hospital-based nurse practitioners' offices, freestanding ambulatory surgery centers, day treatment centers, or the member's home. Such services are as described in Section 1905 of the Social Security Act and the regulations promulgated thereunder.
- c. 1115 Demonstration Allowable Costs
- i. 1115 Demonstration Expenditures: Costs incurred by acute hospitals for providing Medicaid state plan services to members eligible for Medicaid through the 1115 demonstration (i.e., expansion populations) will be counted as allowable costs. In addition, allowable costs of services that are not authorized under the Medicaid state plan and are provided by acute hospitals under the 1115 demonstration include expenditures related to services provided in the programs below and described in the Cost Element table. All services authorized under the section 1115 demonstration are subject to the requirements and limitations specified in the STCs.
    1. The Commonwealth must not claim costs for the Pediatric Asthma Pilot Program until receiving CMS approval of the Pediatric Asthma Program payment protocol as described in Special Term and Condition 40(h).
    2. Intensive Early Intervention Services for Children with Autism Spectrum Disorder. The Commonwealth must not claim costs for the Intensive Early Intervention Services for Children with Autism Spectrum disorder until CMS approves the Intensive

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

Early Intervention Services for Children with Autism Spectrum Disorder the Pediatric Asthma Pilot Program payment protocol as specified in STC 40(h).

3. Diversionary Behavioral Health Services.
  - d. Medicaid Managed Care Costs: Costs incurred by acute hospitals for providing services to members enrolled in Medicaid managed care organizations including Senior Care Organizations (SCOs) and Integrated Care Organization (ICOs), prepaid inpatient health plans, and any prepaid ambulatory health plans. Eligible costs are determined using the same methodology under this section.
  - e. Other Allowable Costs, Approved 1915(c) Waivers – Allowable costs are defined in the Cost Element table.
  - f. Additional Allowable Costs – Allowable costs are defined in the Cost Element table.

**I. Summary of 2552-10 Cost Report (CMS 2552 cost report)**

Worksheet A: Reclassification and Adjustment of Trial Balance of Expenses

Worksheet A provides for recording the trial balance of expense accounts from your accounting books and records. It also provides for the necessary reclassifications and adjustments to certain accounts. Not included on Worksheet A are items that conflict with Medicare regulations, manuals, or instructions but which providers may wish to claim and contest.

The trial balance of expenses is broken down into the following categories to facilitate the transfer of costs to the various worksheets:

- 1) General service cost centers
- 2) Inpatient routine service cost centers
- 3) Ancillary service cost centers
- 4) Outpatient service cost centers
- 5) Other reimbursable cost centers
- 6) Special purpose cost centers
- 7) Other special purpose cost centers not previously identified
- 8) Costs applicable to nonreimbursable cost centers to which general service costs apply
- 9) Nonreimbursable cost center to accumulate the cost incurred by you for services related to the physicians' private practice

Worksheet B

Worksheet B allocates overhead (originally identified as general service cost centers) to all other cost centers, including the non-reimbursable costs identified in lines 96 through 100.

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

Cost finding is the process of recasting data derived from the accounts ordinarily kept by the provider to ascertain costs of the various types of services rendered; i.e., the allocation of the expenses of each general service cost center to those cost centers which receive the services. The CMS 2552 approved method of cost finding is recognized and outlined in 42 CFR 413.24 and is based on the accrual basis of accounting except where government institutions operate on a cash basis of accounting.

Worksheet C

Worksheet C computes the ratio of cost to charges (RCC) for inpatient services, ancillary services, outpatient services, and other reimbursable services. The total cost for each cost center is derived from Worksheet B after the overhead allocation, and the total charge for each cost center is determined from the provider's records. This RCC is used on Worksheet D, Worksheet D-3, Worksheet D-4, Worksheet H-3, and Worksheet J-2 to determine the program's share of ancillary service costs in accordance with 42 CFR 413.53. This worksheet is also needed to determine the adjusted total costs used on Worksheet D-1.

Worksheet D

This series of worksheets is where the total costs from Worksheet B are apportioned to different payer programs. Apportionment is the process by which a cost center's total cost is allocated to a specific payer or program or service type. Apportionment is used to arrive at Medicare hospital inpatient routine and ancillary cost and Medicare hospital outpatient cost, etc.

Worksheet D consists of the following five parts:

- 1) Part I: Apportionment of Inpatient Routine Service Capital Costs
- 2) Part II: Apportionment of Inpatient Ancillary Service Capital Costs
- 3) Part III: Apportionment of Inpatient Routine Service Other Pass Through Costs
- 4) Part IV: Apportionment of Inpatient/Outpatient Ancillary Service Other Pass Through Costs
- 5) Part V: Apportionment of Medical and Other Health Services Costs

Worksheet D-1: All providers will complete this worksheet, which provides for the computation of hospital inpatient operating cost in accordance with 42 CFR 413.53 (determination of cost of services to beneficiaries), 42 CFR 413.40 (ceiling on rate of hospital cost increases), and 42 CFR 412.1 through 412.125 (prospective payment).

Worksheet D-2: Worksheet D-2 apportions the cost of services rendered by interns and residents across the following two parts:

- 1) Part I: Not in Approved Teaching Program. This part is used by the provider only if it has interns and residents that are not in an approved teaching program.

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

- 2) Part II: In an Approved Teaching Program (Title XVIII, Part B Inpatient Routine Costs Only). This part provides for reimbursement for inpatient routine services rendered by interns and residents in approved teaching programs to Medicaid beneficiaries.

Worksheet D-3: Worksheet D-3 apportions inpatient ancillary services.

Worksheet D-4: Worksheet D-4 computes organ acquisition costs and charges for hospitals that are certified transplant centers.

Worksheet D-5: Apportions cost for the services of teaching physicians.

Worksheet E

Worksheet E worksheets will be used to calculate Title XIX settlement for inpatient prospective payment system (IPPS) hospital services, medical and other health services.

NOTES:

For purposes of utilizing the CMS 2552 cost report to determine Medicare reimbursements, the term “as filed 2552 cost report” refers to the cost report filed on or before the last day of the fifth month following the close of the provider’s cost reporting period. The cost reporting period covers a 12-month period of operations based upon the provider’s accounting year.

**II. Uniform Medicaid & Uncompensated Care Cost & Charge Report (UCCR)**

In relation to Medicaid reimbursement, the CMS 2552 report does not sufficiently capture costs for Massachusetts hospitals because costs cannot be allocated across other payers, nor are costs reimbursed through the CMS 2552 inclusive of those incurred for providing the types of services that support the Medicaid-eligible and uninsured populations, such as those approved in this cost limit protocol as additional allowable costs.

The Commonwealth will use the CMS 2552<sup>2</sup> and Uniform Medicaid & Uncompensated Care Cost & Charge Report (UCCR) to determine Medicaid and uninsured costs. To supplement the CMS 2552 cost report, hospitals subject to the cost limit protocol will file the UCCR to allocate allowable 2552 costs to Medicaid

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<sup>2</sup> Community Based Detoxification Centers are the only provider type subject to the cost limit that does not submit the CMS 2552 cost report.



**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

and uninsured services and, in accordance with the Cost Element table, recognize additional costs that are not otherwise reimbursed through the CMS 2552.

The UCCR report includes cost-center specific data by payer and its purpose is to capture uncompensated costs that safety net providers incur from supporting a large proportion of Medicaid and uninsured individuals. The UCCR also captures costs that are specifically allocated toward “funding required for the operation of the Safety Net Health Care System” on Schedule E, which was designed to reflect costs that are incurred disproportionately on behalf of Medicaid and uninsured patients (e.g., social, financial, and interpreter costs; unreimbursed costs for Dual Eligibles, etc. and other additional allowable costs approved in this cost limit protocol).

Overview

Acute hospitals must submit cost, charge and patient day data via the UCCR, an electronic report developed by the Commonwealth, based on the CMS 2552, and currently used to record Medicaid- and uncompensated care costs for certain safety net providers. For the Commonwealth’s use in calculating provider-specific uncompensated care cost limits, data submitted by the provider shall be based on information supplied on the hospital’s CMS 2552, as filed with and audited/settled by the Medicare fiscal intermediary, hospital records, and the UCCR.

NOTES:

The Medicaid- eligible population includes those individuals who are eligible for Medicaid but have private insurance; Medicaid FFS and Medicaid Managed Care, including individuals dually eligible for Medicaid and Medicare.

“Uninsured individuals” for whom uncompensated care costs are allowable includes the population for which HSN payments are made. Costs associated with Medicaid-eligible individuals who are uninsured for the service are allowable under this population, assuming the service meets all other criteria outlined in this protocol, including but not limited to being “medically necessary.” Additionally, costs associated with the Medicaid- eligible population must not be duplicative of the uninsured individual costs.

The costs incurred for providing the services below are approved by CMS as additional allowable services not otherwise captured and/or allocated to the Medicaid-eligible and uninsured population through the CMS 2552 allocation method.

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

For the purposes of the UCCR, a Massachusetts Medicaid Managed Care Organization (otherwise referred to as “MMCO”) includes MCOs, Integrated Care Organizations (ICOs), Senior Care Organizations (SCOs), Programs of All-inclusive Care for the Elderly (PACE), and Prepaid Inpatient or Ambulatory Health Plan (including the behavioral health PIHP).

<b>Cost Element</b>	<b>Inpatient Services</b>	<b>Outpatient Hospital Services</b>	<b>Chronic Disease and Rehab – Inpatient</b>	<b>Chronic Disease and Rehab – Outpatient</b>	<b>Psychiatric Inpatient Hospital</b>	<b>Psychiatric Outpatient Hospital</b>	<b>Substance Abuse Treatment – Inpatient</b>	<b>Substance Abuse Treatment – Outpatient</b>
Professional component of provider-based physician costs, including contracted physician costs, which are not part of the inpatient hospital billing	X	X	X	X	X	X		
Provider component of provider-based physician costs reduced by Medicare reasonable compensation equivalency (RCE) limits, subject to applicable Medicare cost principles	X	X	X	X	X	X		
Administrative costs of the hospital’s billing activities associated with physician services who are employees of the hospital billed and received by the hospital	X	X	X	X	X	X		

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

<b>Cost Element</b>	<b>Inpatient Services</b>	<b>Outpatient Hospital Services</b>	<b>Chronic Disease and Rehab – Inpatient</b>	<b>Chronic Disease and Rehab – Outpatient</b>	<b>Psychiatric Inpatient Hospital</b>	<b>Psychiatric Outpatient Hospital</b>	<b>Substance Abuse Treatment – Inpatient</b>	<b>Substance Abuse Treatment – Outpatient</b>
Patient and community education programs, excluding cost of marketing activities	X	X	X	X	X	X	X	X
Telemedicine services	X	X	X	X	X	X	X	X
Addiction Services	X	X	X	X	X	X		X
Community Psychiatric Support and Treatment		X		X		X		X
Medication Administration		X				X		
Vision Care		X						
Health care for the house bound and the homeless, family planning, and pre-natal, labor, and post-natal support for at risk pregnancies. CMS 255-10, Line 193		X						
Social, Financial, Interpreter, Coordinated Care and other services for Medicaid-eligible and uninsured patients	X	X	X	X	X	X	X	X
340b and other pharmacy costs		X						
Graduate Medical Education	X	X	X	X	X	X		

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

Cost Element	Inpatient Services	Outpatient Hospital Services	Chronic Disease and Rehab – Inpatient	Chronic Disease and Rehab – Outpatient	Psychiatric Inpatient Hospital	Psychiatric Outpatient Hospital	Substance Abuse Treatment – Inpatient	Substance Abuse Treatment – Outpatient
Outlier Day: Each day beyond 20 acute days, during a single admission, for which a member remains hospitalized at acute status	X							
Psychiatric Day Treatment Program Services		X				X		
Dental Services		X						
Intensive Early Intervention Services for Children with Autism Spectrum Disorder	X	X						
Diversionsary Behavioral Health Services	X	X	X	X	X	X	X	X
Public Hospital Pensions and Retiree Benefits	X	X						

**UCCR Instructions**

Schedule A: Computation of MassHealth Fee-for-Service (FFS) Costs

*Column 1 – Reported Costs*

Enter costs from the hospital’s most recently filed Medicare cost report (CMS 2552) Worksheet B, Part 1, column 24. This column includes costs that have already been reclassified, adjusted and stepped down through the A and B worksheet series and includes costs related to interns and residents.

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

*Column 2 – Reclassification of Observation Costs and inclusion of Post-Stepdown Costs*

Reclassify observation costs from Line 30 to Line 92. The observation costs are derived from the CMS-2552, Worksheet C, Part I, Column 5, Line 92.

Add post-step-down costs from Supplemental Worksheet B-2, Column 4, Lines 54, 60, 89 & 90, except costs related to interns and residents.

For line 30 (Adults and Pediatrics), include a decreasing adjustment, if applicable, for the swing bed costs reported on Worksheet D-1, Part I, line 26, and for the private room differential costs reported on Worksheet D-1, Part I, line 36.

*Column 3 – Total Costs*

Sum of costs from column 1 and column 2. [This column will auto-populate.]

*Column 4 – Charges*

Enter charges from the hospital's most recently filed Medicare cost report (CMS 2552) Worksheet C, Part I, column 8.

*Column 5 – Hospital Cost-to-Charge Ratios*

Calculate the cost-to-charge ratio for each cost center by dividing the total costs for each cost center from column 3 by the respective charges from column 4. [This column will auto-populate.]

*Column 6 – Total MassHealth Fee-for-Service Inpatient Charges:*

Enter from hospital records inpatient charges by cost center related to MassHealth Fee-for-Service (FFS) patients.

- MassHealth FFS Inpatient Charges include only those charges for the following:
  - Medically necessary services as defined in 130 CMR 450.204;
  - MassHealth covered inpatient hospital services provided to MassHealth patients eligible pursuant to Titles XIX and XXI at the time of service delivery.

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

- MassHealth FFS Inpatient Charges may not include:
  - Charges associated with services provided to MassHealth members where the service is covered by a Medicaid Managed Care Organization;
  - Charges associated with claims that have been final denied for payment by MassHealth;
  - Charges associated with state programs that are not Title XIX and Title XXI programs (e.g., the Children’s Medical Security Plan);
  - Charges associated with the professional component of hospital-based physician services.

*Column 7 – MassHealth FFS Inpatient Costs*

For Lines 50 through 117, calculate the MassHealth FFS inpatient costs by multiplying for each cost center the MassHealth FFS inpatient charges from column 8 by the respective hospital cost-to-charge ratios from column 5. [These lines will auto-populate.] For lines 30-46, costs are determined using a per diem methodology; these cells will automatically be populated after Schedule B (column 5) has been completed.

*Column 8 – MassHealth Fee-for-Service Outpatient Charges*

Enter from hospital records outpatient charges by cost center related to MassHealth Fee-for-Service (FFS) patients.

- MassHealth FFS Outpatient Charges include only those charges for the following:
  - Medically necessary services as defined in 130 CMR 450.204; and
  - MassHealth covered outpatient hospital services provided to MassHealth patients eligible pursuant to Titles XIX and XXI at the time of service delivery.
- MassHealth FFS Outpatient Charges may not include:
  - Charges associated with services provided to MassHealth members where the service is covered by a Medicaid Managed Care Organization;
  - Charges associated with claims that have been final denied for payment by MassHealth;
  - Charges associated with state programs that are not Title XIX or Title XXI programs (e.g., the Children’s Medical Security Plan); or

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

- Charges associated with the professional component of hospital-based physician services.

*Column 9 – MassHealth Fee-for-Service Outpatient Costs*

MassHealth FFS outpatient costs are determined by multiplying the MassHealth outpatient charges for each cost center from column 8 by the respective hospital cost-to-charge ratios from column 5. [This column will auto-populate.]

*Column 10 – Total MassHealth Fee-for-Service Inpatient and Outpatient Costs*

Total MassHealth FFS costs are determined by adding the MassHealth inpatient costs from column 7 and the MassHealth outpatient costs from column 9. [This column will auto-populate.]

Schedule B: Computation of Inpatient Routine Cost Center Per Diems

For the purposes of completing Schedule B, patient days entered in Columns 2, 4, 6 and 8 must include only those days wherein a patient fully met, at the time of service, the criteria for the given category (FFS, MMCO, HSN and Uninsured Care), as set forth in the Instructions to Schedules A and C. The SNF, NF, and LTC cost centers must be removed from Schedule B, since these costs cannot be claimed as part of the hospital uncompensated care costs.

*Column 1 – Total Routine Cost Center Inpatient Costs*

Enter total costs for each routine cost center as reported on UCCR Schedule A, Column 3, lines 30-46. [This column will auto-populate.]

*Column 2 – Total Inpatient Days*

Enter total patient days for each routine cost center from CMS-2552 Worksheet S-3, Part 1, Column 8.

*Column 3 – Per Diem*

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

Calculate the average cost per day (per diem) by dividing total costs for each cost center in column 1 by the respective total patient days in column 2. [This column will auto-populate.]

*Column 4 – MassHealth Fee-for-Service Inpatient Days*

Enter total MassHealth FFS inpatient days for each routine cost center on lines 30-46 from provider records.

*Column 5 – Total MassHealth FFS Inpatient Costs*

Calculate total FFS inpatient costs for each routine cost center by multiplying the days in column 4 by the per diem in column 3. [This column will auto-populate.]

*Column 6 – Medicaid Managed Care Inpatient Days*

Enter total Medicaid Managed Care inpatient days for each routine cost center on lines 30-46 from provider records.

*Column 7 – Total Medicaid Managed Care Inpatient Costs*

Calculate total MMCO inpatient costs for each routine cost center by multiplying the days in column 6 by the per diem in column 3. [This column will auto-populate.]

*Column 8 – HSN and Uninsured Care Inpatient Days*

Enter total HSN and Uninsured Care inpatient days for each routine cost center on lines 30-46 from provider records.

*Column 9 – Total HSN and Uninsured Care Inpatient Costs*

Calculate total HSN and Uninsured Care inpatient costs for each routine cost center by multiplying the days in column 8 by the per diem in column 3. [This column will auto-populate.]

Schedule C: Computation of Massachusetts Medicaid Managed Care (MMCO) and HSN and Uninsured Costs



**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

For the purposes of completing Schedule C:

- Massachusetts Medicaid Managed Care Charges include only those charges for the following:
  - Medically necessary services as defined in 130 CMR 450.204;
  - MassHealth covered inpatient and outpatient hospital services provided to MassHealth patients eligible pursuant to Titles XIX and XXI and enrolled in a MassHealth contracting MCO, SCO, PACE, PIHP and PAHP (MMCO) at the time of service delivery.
- Medicaid Managed Care Charges may not include:
  - Charges associated with services provided to MassHealth members where the service is covered under MassHealth Fee-for-Service, including the Primary Care Clinician program;
  - Charges associated with claims that have been final denied for payment by the MMCO;
  - Charges associated with state programs that are not Title XIX and Title XXI programs (e.g., the Children's Medical Security Plan);
  - Charges reported as HSN and Uninsured Care (below).
- HSN and Uninsured Care Inpatient and Outpatient Charges are defined as those charges associated with care provided by hospitals for medically necessary services, including services reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity provided to:
  - Individuals with no health insurance coverage;
  - Low-Income Patients (under state regulation 114.6 CMR 12.03 (3) or (4) or its successor regulation) with no health insurance coverage;
  - Low-Income Patients (under state regulation 114.6 CMR 12.03 (3) or (4) or its successor regulation) whose public or private health insurance plan does not cover the cost of the particular service (excluding unpaid coinsurance and/or deductible amounts); or
  - Medicaid-eligible patients whose medical service is not paid by MassHealth or the Massachusetts Medicaid Managed Care Organizations, SCO, ICO, PACE, PIHP or PAHP;
- HSN and Uninsured Care Charges, for the purpose of Schedule C of the UCCR, shall exclude charges associated with:
  - Professional component of physician charges;

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

- Overhead charges related to physician services.

*Column 1 – Hospital Cost-to-Charge Ratios*

Enter the hospital cost-to-charge ratio for each cost center from Schedule A: MassHealth Fee-for-Service (FFS) Costs column 5. [This column will auto-populate.]

*Column 2 – Massachusetts Medicaid Managed Care Inpatient Charges*

Enter from hospital records inpatient charges, by cost center, related to Massachusetts Medicaid managed care patients.

*Column 3 – Massachusetts Medicaid Managed Care Inpatient Costs*

Massachusetts Medicaid managed care inpatient costs are determined by multiplying the Massachusetts Medicaid managed care inpatient charges for each cost center from column 2 by the respective hospital cost-to-charge ratios from column 1. However, for lines 30-46, costs are determined using a per diem methodology via Schedule B. [This column will auto-populate.]

*Column 4 – Massachusetts Medicaid Managed Care Outpatient Charges*

Enter from hospital records outpatient charges, by cost center, related to Massachusetts Medicaid managed care patients.

*Column 5 – Massachusetts Medicaid Managed Care Outpatient Costs*

Massachusetts Medicaid managed care outpatient costs are determined by multiplying the Massachusetts Medicaid managed care outpatient charges for each cost center from column 4 by the respective hospital cost-to-charge ratios from column 1.

*Column 6 – Total Massachusetts Medicaid Managed Care Inpatient and Outpatient Costs*

Total Massachusetts Medicaid managed care inpatient and outpatient costs are determined by adding the Massachusetts Medicaid managed care inpatient costs from column 3 and the Massachusetts Medicaid managed care outpatient costs from column 5.

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

*Column 7 – HSN and Uninsured Care Inpatient Charges*

Enter from hospital records inpatient charges, by cost center, related to HSN and Uninsured Care patients.

*Column 8 – HSN and Uninsured Care Inpatient Costs*

For Lines 50 through 117, HSN and Uninsured Care inpatient costs are determined by multiplying the HSN and Uninsured Care inpatient charges for each cost center from column 7 by the respective hospital cost-to-charge ratios from column 1; for lines 30-46, costs are determined using a per diem methodology via Schedule B. [This column will auto-populate through line 94.]

*Column 9 – HSN and Uninsured Care Outpatient Charges*

Enter from the hospital records outpatient charges by cost center related to HSN and Uninsured Care patients.

*Column 10 – HSN and Uninsured Care Outpatient Costs*

Uncompensated care outpatient costs are determined by multiplying the HSN and Uninsured Care outpatient charges for each cost center from column 9 by the respective hospital cost-to-charge ratios from column 1.

*Column 11 – Total HSN and Uninsured Care Costs*

Total HSN and Uninsured Care inpatient and outpatient costs are determined by adding the HSN and Uninsured Care inpatient costs from column 8 and the HSN and Uninsured Care outpatient costs from column 10.

Schedule D: Computation of Uncompensated Physician Costs

For purposes of completing Schedule D:

Uncompensated Physician Costs are limited to those charges incurred by hospital-based physicians for professional services.

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

- MassHealth FFS Charges include only those charges for the following:
  - Medically necessary services as defined in 130 CMR 450.204;
  - MassHealth covered hospital-based physician professional services provided to MassHealth patients eligible pursuant to Titles XIX and XXI at the time of service delivery.
  - Charges associated with the professional component of hospital-based physicians services.
  
- MassHealth FFS Hospital-Based Physician Professional Charges may not include:
  - Charges associated with services provided to MassHealth members where the service is covered by a Medicaid Managed Care Organization;
  - Charges associated with claims that have been final denied for payment by MassHealth;
  - Charges associated with state programs that are not Title XIX and Title XXI programs (e.g., the Children’s Medical Security Plan);
  
- Massachusetts Medicaid Managed Care Charges include only those charges for the following:
  - Medically necessary services as defined in 130 CMR 450.204;
  - MassHealth covered hospital-based physician professional services provided to MassHealth patients eligible pursuant to Titles XIX and XXI and enrolled in a MassHealth contracting MCO, SCO, PACE, PIHP and PAHP (MMCO) at the time of service delivery;
  - Charges associated with professional component of hospital-based physician services.
  
- Medicaid Managed Care Charges may not include:
  - Charges associated with services provided to MassHealth members where the service is covered under MassHealth Fee-for-Service, including the Primary Care Clinician program;
  - Charges associated with claims that have been final denied for payment by the MMCO;
  - Charges associated with state programs that are not Title XIX and Title XXI programs (e.g., the Children’s Medical Security Plan);
  - Charges reported as HSN and Uninsured Care (below).
  
- HSN and Uninsured Physician Charges are defined as those physician charges associated with care provided for medically necessary services, including services reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity provided to:

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

- Individuals with no health insurance coverage;
- Low-Income Patients (under state regulation 114.6 CMR 12.03 (3) or (4) or its successor regulation) with no health insurance coverage;
- Low-Income Patients (under state regulation 114.6 CMR 12.03 (3) or (4) or its successor regulation) whose public or private health insurance plan does not cover the cost of a particular service (excluding unpaid coinsurance and/or deductible amounts); or
- Medicaid-eligible patients whose medical service is not paid by MassHealth or the Massachusetts Medicaid Managed Care Organizations, SCO, ICO, PACE, PIHP or PAHP;

*Column 1 – Professional Component of Physicians’ Costs*

The professional component of physicians’ costs come from the hospital’s most recently filed Medicare cost report (CMS 2552) Worksheet A-8-2, column 4.

*Column 2 – Overhead Costs Related to Physicians’ Services*

If the overhead costs related to physicians’ services were adjusted out of the physicians’ costs entered on Worksheet A-8-2, enter those overhead costs from Worksheet A-8 to the corresponding cost center.

*Column 3 – Total Physicians’ Costs*

Total Physicians’ costs are determined by adding column 1 and column 2. [This column will auto-populate.]

*Column 4 – Total Physician Inpatient and Outpatient Charges*

Enter the total charges related to physician inpatient and outpatient services from hospital records to the corresponding cost center.

*Column 5 – Cost-to-Charge Ratios*

For each cost center, a cost-to-charge ratio is calculated by dividing total physicians’ costs in column 3 by total physician charges in column 4. [This column will auto-populate.]

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

*Column 6* – MassHealth FFS Physician Inpatient and Outpatient Charges

Enter by cost center the total charges related to physician inpatient and outpatient services for MassHealth FFS patients from hospital records.

*Column 7* – MassHealth FFS Physician Inpatient and Outpatient Costs

MassHealth FFS physician inpatient and outpatient costs are determined for each cost center by multiplying the MassHealth FFS inpatient and outpatient physician charges from column 6 by the cost-to-charge ratio from column 5. [This column will auto-populate.]

*Column 8* – Massachusetts Medicaid Managed Care Physician Inpatient and Outpatient Charges

Enter the total charges related to physician inpatient and outpatient services for Massachusetts Medicaid managed care patients from hospital records.

*Column 9* – Massachusetts Medicaid Managed Care Physician Inpatient and Outpatient Costs

Massachusetts Medicaid managed care physician inpatient and outpatient costs are determined for each cost center by multiplying the Massachusetts Medicaid managed care inpatient and outpatient physician charges from column 8 by the cost-to-charge ratio from column 5. [This column will auto-populate.]

*Column 10* – HSN and Uninsured Care Physician Inpatient and Outpatient Charges

From provider records, enter the charges related to physician inpatient and outpatient services for HSN and Uninsured Care patients as defined above.

*Column 11* – HSN and Uninsured Care Physician Inpatient and Outpatient Costs

HSN and Uninsured Care physician inpatient and outpatient costs are determined for each cost center by multiplying the HSN and Uninsured Care inpatient and outpatient physician charges from column 10 by the cost-to-charge ratio from column 5. [This column will auto-populate.]

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

*Column 12* – Total Massachusetts Medicaid Fee-for-Service, Medicaid Managed Care and HSN and Uninsured Care Inpatient and Outpatient Physician Costs

Total Massachusetts Medicaid fee-for-service, managed care and HSN and Uninsured Care inpatient and outpatient physician costs are determined by adding column 7, column 9 and column 11.

Schedule E: Safety Net Health Care System (SNCHS) Expenditures

Pursuant to Section 49 (c) of the 1115 demonstration Special Terms and Conditions, expenditures for payments to providers is authorized under the safety net care pool to support uncompensated care for “Medicaid FFS, Medicaid managed care, and low-income uninsured individuals.” This Schedule E provides health care providers the opportunity to itemize such system expenditures for the Medicaid-eligible and uninsured population and includes the additional allowable costs outlined in the Development Tool approved by CMS on September 6, 2013 and any additional allowable costs described in the Cost Element table of this document.

*Column 1* – Total System Expenditures

Enter total safety net health care system expenditures for each line item.

*Column 2* – Medicaid-eligible / HSN and Uninsured Payer Mix Proportion

To determine the proportion of total system expenditures attributable to Medicaid-eligible and uninsured patients, first estimate the total charges for the year attributable to this group; next, estimate the total charges for the year attributable to all patients served by the SNHCS. The ratio of these two numbers will be used to estimate the amount of system expenditures attributable to Medicaid-eligible and uninsured patients. Enter this ratio in column 2. Should an alternative ratio be more appropriate, enter that number, and then explain the basis for it in the Narrative Description section of Schedule E.

*Column 3* – Medicaid-eligible / HSN and Uninsured Share of System Expenditures

Calculate the system expenditures attributable to Medicaid-eligible and uninsured patients by multiplying the total system expenditure in column 1 by the payer mix proportion in column 2. [This column will auto-populate.]

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

Schedule F: Medicaid and Uninsured Revenue

Note: Hospitals must ensure that any applicable revenues pertaining to Medicaid or uninsured costs allowed in Schedule E are captured in Schedule F and are treated as an offset to arrive at net uncompensated care costs.

Line Instructions:

Hospital and Clinic Revenue:

In lines 1-8, enter amounts paid for services provided by the hospital and any provider-based satellites, including hospital-licensed health centers.

Line 1 – Payer Medical Claims Revenue

For each column, enter in line 1 the total amount paid by the payer for medical claims. Do not include payments for that are not related to claims, such as pay-for-performance payments or supplemental payments. The amounts reported must reflect any post-payment reconciliations or recoupments, subject to the availability of that data.

Column 5 - Health Safety Net and Uninsured

In line 1, column 5, report the gross payments received from the HSN and Uninsured. Do not offset the amount of the HSN Assessment.

Line 2 – Pay-for-Performance / Incentive Payment Revenue

This revenue data is reported for informational purposes only. Payments that are not service payments for the provision of medical care are not offset against the eligible cost. Since the following payments are not payments for the provision of medical care, they are not offset against the eligible cost: SNCP grants and performance-based, incentive, and shared savings payments. These include performance-based and incentive-based payments and grants and awards both currently in existence and those that may be approved and implemented during future demonstration renewal periods.

Enter in line 2 any amounts paid by the payer for pay-for-performance or other incentive payments. The amount reported must also include any recoveries made by the payer for performance issue, such as retrospective performance penalties.

Line 3-5 – Supplemental Payments

Enter in lines 3-5 any amounts paid by the payer for supplemental payments. Specify the type of supplemental payment reported by modifying the title of the line. The total



**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

gross payment must be reported; do not offset any payment amount by any intergovernmental transfer amounts that may have been made by a related public entity.

**Line 6 – Medicare Revenue**

Enter in line 6 any payments amounts received by Medicare for services provided to patients who are eligible for both Medicare and the payer noted in the column.

**Line 7 – Third Party and Self Pay Revenue**

Enter in line 7 any payment amounts received by third parties, the patient, or the patient's guarantor for the cost-sharing or services not covered by the payer noted in the column.

**Line 8 – Other Revenue**

Enter in line 8 any additional revenue from the payer for the Medicaid-eligible and uninsured populations not included in lines 1-7. Specify the type of revenue by modifying the title of the line. Additional information may be provided in the Notes tab.

**Line 9 – Subtotal Hospital and Clinic**

Sum of lines 1-8. [This line will auto-populate.]

**Lines 10-15 Physician Revenue**

Using the same descriptions in the corresponding lines 1-8, report physician revenue related to the payers.

**Line 16 – Subtotal Physician Revenue**

Sum of lines 10-15. [This line will auto-populate.]

**Line 17 – Total Revenue.**

Sum of lines 9 and 16. [This line will auto-populate.]

Column Instructions.

*Column 1 – Medicaid FFS Inpatient Revenue*

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

Report in column 1, amounts paid by MassHealth for inpatient services provided to members enrolled in the MassHealth program, excluding those enrolled in MassHealth managed care programs.

*Column 2 – Medicaid FFS Outpatient Revenue*

Report in column 2, amounts paid by MassHealth for outpatient services provided to members enrolled in the MassHealth program, excluding those enrolled in MassHealth managed care programs.

*Column 3 – Medicaid Managed Care Inpatient Revenue*

Report in column 3, amounts paid by Medicaid Managed Care Organizations for inpatient services provided to members.

*Column 4 – Medicaid Managed Care Outpatient Revenue*

Report in column 4, amounts paid by Medicaid Managed Care Organizations for outpatient services provided to members.

*Column 5 – HSN and Uninsured Inpatient and Outpatient Revenue*

Report in column 5, amounts paid by the HSN and uninsured individuals for inpatient and outpatient services provided. Report the gross payments received from the HSN. Do not offset the amount of the HSN Assessment.

*Column 6 – Total Revenue*

Sum of columns 1 through 5. [This column will auto-populate.]

Schedule G: Notes

Providers may use Schedule G to provide additional information on the data reported.

**III. Reconciliation**

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

Interim Reconciliation

Each provider's uncompensated care costs must be computed based on the provider's as-filed CMS 2552<sup>3</sup> cost report and Uniform Medicaid & Uncompensated Care Cost & Charge Report (UCCR) and for the actual service period. The CMS 2552 cost report is filed with the Medicare contractor five months after the close of the cost reporting period. The UCCR must be filed three months after the CMS 2552 is filed. For SNCP payments subject to the cost limit pursuant to STC 49(c), each provider's allowable Medicaid, uncompensated care, and uninsured costs must be reconciled against associated applicable payments received for the year for which the payments were made.

For hospitals whose accounting fiscal year aligns with the cost limit reporting fiscal year (Federal fiscal year), the Medicaid and uninsured costs will be reflected in the CMS 2552 and UCCR that is submitted for the accounting fiscal year. For acute hospitals whose accounting fiscal years do not align with the reporting fiscal year, the reporting year cost limit will be calculated by applying the appropriate percentage of the two contiguous CMS 2552 and UCCR cost reports that span the reporting fiscal year so that the Federal fiscal year will be represented in the cost limit calculation.

The Commonwealth must recover provider overpayments as it determines necessary based on its reconciliation calculations and availability of federal financial participation.

If an overpayment exists, the Commonwealth must determine if the overpayment occurred due to Health Safety Net (HSN) Trust Fund payments or other SNCP payments, or from both payments. To the extent that the overpayment is a result of overpaid funds from the HSN Trust Fund payments, the Commonwealth must recover from the provider the amount overpaid to the provider from the HSN Trust Fund and credit that amount to the HSN Trust Fund. The HSN Trust Fund will redistribute such amounts to other providers as appropriate. To the extent that the overpayment is not the result of HSN Trust Fund payments, the Commonwealth must recover from the provider the overpayment, and the Commonwealth must properly credit the federal share to the federal government.

The interim reconciliation described above must be performed and completed within twelve months after the filing of the UCCR(s).

Final Reconciliation

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<sup>3</sup> Community Based Detoxification Centers are the only provider type subject to the cost limit that does not submit the CMS 2552 cost report.

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

Each provider's uncompensated care costs must be recomputed based on the provider's audited CMS 2552 cost report for the actual service period. These recomputed costs must be carried over to the UCCR. The CMS 2552 cost report is audited and settled by the Medicare contractor to determine final allowable costs and reimbursement amounts as recognized by Medicare. For SNCP payments subject to the cost limit pursuant to STC 49(c), each provider's allowable Medicaid, uncompensated care, and uninsured costs must be reconciled against associated applicable payments received for the year for which the payments were made. SNCP uncompensated care payments made to the provider for a cost limit reporting year cannot exceed the recomputed uncompensated care cost limit. If, at the end of the final reconciliation process, it is determined that expenditures claimed exceeded the individual provider's uncompensated care cost limit, thereby causing an overpayment, the Commonwealth must recoup the overpayment from the provider. Specifically, if an overpayment exists, the Commonwealth must determine if the overpayment occurred due to HSN Trust Fund payments or other SNCP payments, or from both payments. To the extent that the overpayment is a result of overpaid funds from the HSN Trust Fund, the Commonwealth must recover from the provider the amount overpaid to the provider from the HSN Trust Fund and credit that amount to the HSN Trust Fund. The HSN Trust Fund will redistribute such amounts to other providers as appropriate. To the extent that the overpayment is not the result of HSN Trust Fund payments, the Commonwealth must recover from the provider the overpayment, and the Commonwealth must properly credit the federal share to the federal government.

For hospitals whose accounting fiscal year aligns with the cost limit reporting fiscal year (Federal fiscal year), the Medicaid and uninsured costs will be reflected in the CMS 2552 and UCCR that is submitted for the accounting fiscal year. For acute hospitals whose accounting fiscal years do not align with the reporting fiscal year, the reporting year cost limit will be calculated by applying the appropriate percentage of the two contiguous CMS 2552 and UCCR cost reports that span the reporting fiscal year so that the Federal fiscal year will be represented in the cost limit calculation.

The Commonwealth must recover provider overpayments as it determines necessary based on its reconciliation calculations and availability of federal financial participation.

The final reconciliation described above must be performed and completed within twelve months after all final, audited CMS 2552 cost reports become available online.

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

**Public Chronic Disease & Rehabilitation and Psychiatric Inpatient and Outpatient  
Hospital Protocol for Medicaid and Uncompensated Care Cost**

Determination of Allowable Medicaid and Uninsured Costs

- a. DSH Allowable Costs
  - i. Per STC 50(f), the cost limit protocol will use the Medicaid DSH statutory, regulatory, and policy definitions of allowable inpatient hospital and outpatient hospital services and allowable Medicaid and uninsured costs in determining hospital-specific cost limits. To the extent that the determination of uncompensated care costs varies from the Medicaid DSH requirements, the process must be accounted for in this document.
  - ii. Allowable pharmacy costs include the cost of drugs and pharmacy supplies requested by patient care departments and drugs charged to patients. Pharmacy service costs that are not part of an inpatient or outpatient service, such as retail pharmacy costs, are not considered eligible for inclusion in the hospital-specific uncompensated cost limit allowable under DSH. To the extent that the determination of allowable pharmacy costs varies from the Medicaid DSH requirements, the process must be accounted for in this document.
  - iii. Costs included must be for services that meet the federal definition and the approved Massachusetts State plan definition of “hospital services” for medical assistance. “Medical assistance” is defined as the cost of care and services “for individuals, and, with respect to physicians’ or dentists’ services, at the option of the State, to individuals [who are eligible]...” Section 1905 of the Act.
- b. Medicaid State Plan Allowable Costs
  - i. Massachusetts must use the same definition for all inpatient hospital, outpatient hospital, and physician services, clinic services, non-hospital services, etc. as described in its approved Medicaid state plan, and in accordance with Section 1905 of the Social Security Act and the regulations promulgated thereunder, to define allowable service costs provided by inpatient and outpatient hospitals. Massachusetts identifies other service costs, subject to CMS approval, that are not included in the Medicaid state plan definitions to be included as allowable uncompensated care costs in this document (see Cost Element table).
    - 1. Inpatient chronic disease and rehabilitation hospital services: Inpatient services are routine and ancillary services that are provided to recipients admitted as patients to a chronic disease or rehabilitation hospital. Such services

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

- are as described in Section 1905 of the Social Security Act and the regulations promulgated thereunder.
2. Inpatient psychiatric hospital services: Psychiatric treatment provided under the direction of a psychiatrist in a psychiatric inpatient hospital. Such services are as described in Section 1905 of the Social Security Act and the regulations promulgated thereunder.
  3. Outpatient chronic disease and rehabilitation hospital services: Rehabilitative and medical services provided to a member in a chronic disease or rehabilitation outpatient setting including but not limited to chronic disease or rehabilitation hospital outpatient departments, hospital-licensed health centers or other hospital satellite clinics, physicians' offices, nurse practitioners' offices, freestanding ambulatory surgery centers, day treatment centers, or the member's home. Such services include, but are not limited to, radiology, laboratory, diagnostic testing, therapy services (i.e., physical, speech, occupational and respiratory) and Day surgery services. Such services are as described in Section 1905 of the Social Security Act and the regulations promulgated thereunder.
  4. Outpatient psychiatric hospital services: Services provided to members on an outpatient basis in a psychiatric hospital. Such services are as described in Section 1905 of the Social Security Act and the regulations promulgated thereunder.
- c. 1115 Demonstration Allowable Costs
- i. 1115 Demonstration Expenditures: Costs incurred by psychiatric and chronic disease and rehabilitation hospitals for providing services to members eligible for Medicaid through the section 1115 demonstration (i.e., expansion populations) will be counted as allowable costs. In addition, allowable costs of services that are not authorized under the 1115 demonstration include expenditures related to services provided in the programs below and described in the Cost Element table. All services authorized under the section 1115 demonstration are subject to the requirements and limitations specified in the STCs.
    1. Diversionary Behavioral Health Services.
- d. Medicaid Managed Care Costs: Costs incurred by psychiatric and chronic disease and rehabilitation hospitals for providing services to members enrolled in Medicaid managed care organizations including SCOs and ICOs, prepaid inpatient health plans, and any prepaid ambulatory health plans. Eligible costs are determined using the same methodology under this section.

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

- e. Other Allowable Costs, Approved 1915(c) Waivers – Allowable costs are defined in the Cost Element table.
- f. Additional Allowable Costs – Allowable costs are defined in the Cost Element table.

**I. Certified Public Expenditures – Determination of Allowable Safety Net Care Pool Costs**

In accordance with the approved MassHealth Section 1115 demonstration, beginning July 1, 2014, the estimated fiscal year expenditures will be based on the actual fiscal year CMS 2552 and UCCR cost reports.

General Description of Methodology

The certified public expenditures (CPEs) for special population State-Owned Non-Acute hospitals operated by the Department of Public Health (DPH) and Department of Mental Health (DMH) are claimed annually under the Safety Net Care Pool (SNCP) based upon the unreimbursed Medicaid and uninsured. The CPE interim payments made under the SNCP will follow the same methodology as contained in the Commonwealth's Medicaid State Plan.

**II. Summary of 2552-10 Cost Report**

Worksheet A: Reclassification and Adjustment of Trial Balance of Expenses  
Worksheet A provides for recording the trial balance of expense accounts from your accounting books and records. It also provides for the necessary reclassifications and adjustments to certain accounts. Not included on Worksheet A are items that conflict with Medicare regulations, manuals, or instructions but which providers may wish to claim and contest.

The trial balance of expenses is broken down into the following categories to facilitate the transfer of costs to the various worksheets:

- 1) General service cost centers
- 2) Inpatient routine service cost centers
- 3) Ancillary service cost centers
- 4) Outpatient service cost centers
- 5) Other reimbursable cost centers
- 6) Special purpose cost centers
- 7) Other special purpose cost centers not previously identified
- 8) Costs applicable to nonreimbursable cost centers to which general service costs apply

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

- 9) Nonreimbursable cost center to accumulate the cost incurred by you for services related to the physicians' private practice

Worksheet B

Worksheet B allocates overhead (originally identified as general service cost centers) to all other cost centers, including the non-reimbursable costs identified in lines 96 through 100.

Cost finding is the process of recasting data derived from the accounts ordinarily kept by the provider to ascertain costs of the various types of services rendered; i.e., the allocation of the expenses of each general service cost center to those cost centers which receive the services. The CMS 2552 approved method of cost finding is recognized and outlined in 42 CFR 413.24 and is based on the accrual basis of accounting except where government institutions operate on a cash basis of accounting.

Worksheet C

Worksheet C computes the ratio of cost to charges (RCC) for inpatient services, ancillary services, outpatient services, and other reimbursable services. The total cost for each cost center is derived from Worksheet B after the overhead allocation, and the total charge for each cost center is determined from the provider's records. This RCC is used on Worksheet D, Worksheet D-3, Worksheet D-4, Worksheet H-3, and Worksheet J-2 to determine the program's share of ancillary service costs in accordance with 42 CFR 413.53. This worksheet is also needed to determine the adjusted total costs used on Worksheet D-1.

Worksheet D

This series of worksheets is where the total costs from Worksheet B are apportioned to different payer programs. Apportionment is the process by which a cost center's total cost is allocated to a specific payer or program or service type. Apportionment is used to arrive at Medicare hospital inpatient routine and ancillary cost and Medicare hospital outpatient cost, etc.

Worksheet D consists of the following five parts:

- 1) Part I: Apportionment of Inpatient Routine Service Capital Costs
- 2) Part II: Apportionment of Inpatient Ancillary Service Capital Costs
- 3) Part III: Apportionment of Inpatient Routine Service Other Pass Through Costs
- 4) Part IV: Apportionment of Inpatient/Outpatient Ancillary Service Other Pass Through Costs
- 5) Part V: Apportionment of Medical and Other Health Services Costs

Worksheet D-1: All providers will complete this worksheet, which provides for the computation of hospital inpatient operating cost in accordance with 42 CFR 413.53



**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

(determination of cost of services to beneficiaries), 42 CFR 413.40 (ceiling on rate of hospital cost increases), and 42 CFR 412.1 through 412.125 (prospective payment).

Worksheet D-2: Worksheet D-2 apportions the cost of services rendered by interns and residents across the following two parts:

- 1) Part I: Not in Approved Teaching Program. This part is used by the provider only if it has interns and residents that are not in an approved teaching program.
- 2) Part II: In an Approved Teaching Program (Title XVIII, Part B Inpatient Routine Costs Only). This part provides for reimbursement for inpatient routine services rendered by interns and residents in approved teaching programs to Medicaid beneficiaries.

Worksheet D-3: Worksheet D-3 apportions inpatient ancillary services.

Worksheet D-4: Worksheet D-4 computes organ acquisition costs and charges for hospitals that are certified transplant centers.

Worksheet D-5: Apportions cost for the services of teaching physicians.

Worksheet E

Worksheet E worksheets will be used to calculate Title XIX settlement for inpatient prospective payment system (IPPS) hospital services, medical and other health services.

**NOTES:**

For purposes of utilizing the CMS 2552 cost report to determine Medicare reimbursements, the term “as filed 2552 cost report” refers to the cost report filed on or before the last day of the fifth month following the close of the provider’s cost reporting period. The cost reporting period covers a 12-month period of operations based upon the provider’s accounting year.

**III. Uniform Medicaid & Uncompensated Care Cost & Charge Report (UCCR)**

In relation to Medicaid reimbursement, the CMS 2552 report does not sufficiently capture costs for Massachusetts providers because costs cannot be allocated across other payers, nor are costs reimbursed through the CMS 2552 inclusive of those incurred for providing the types of services that support the Medicaid-eligible and uninsured populations, such as those approved in this cost limit protocol as additional allowable costs.

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

The Commonwealth will use the CMS 2552<sup>4</sup> and Uniform Medicaid & Uncompensated Care Cost & Charge Report (UCCR) to determine Medicaid and uninsured costs. To supplement the Medicare 2552 cost report, hospitals subject to the cost protocol will file the UCCR to allocate allowable 2552 costs to Medicaid and uninsured services and, in accordance with the Cost Element table, recognize additional costs that are not otherwise reimbursed through the CMS 2552.

The UCCR report includes cost-center specific data by payer and its purpose is to capture uncompensated costs that safety net providers incur from supporting a large proportion of Medicaid-eligible and uninsured individuals. The UCCR also captures costs that are specifically allocated toward “funding required for the operation of the Safety Net Health Care System” on Schedule E, which was designed to reflect costs that are incurred disproportionately on behalf of Medicaid-eligible and uninsured patients (e.g., social, financial, and interpreter costs; unreimbursed costs for Dual Eligibles, etc. and other additional allowable costs approved in this cost limit protocol).

Overview

Public Chronic Disease & Rehabilitation and Psychiatric Inpatient and Outpatient Hospitals must submit cost, charge and patient day data via the UCCR, an electronic report developed by the Commonwealth based on the 2552 and currently used to record Medicaid and uncompensated care costs for certain safety net providers. For the Commonwealth’s use in calculating provider-specific uncompensated care cost limits, data submitted by the provider shall be based on information supplied on the hospital’s CMS 2552, as filed with and audited/settled by the Medicare fiscal intermediary, hospital records, and the UCCR.

NOTES:

The Medicaid-eligible population includes those who are eligible for Medicaid but have private insurance; Medicaid FFS and Medicaid Managed Care, including individuals dually eligible for Medicaid and Medicare.

“Uninsured individuals” for whom uncompensated care costs are allowable includes the population for which HSN payments are made. Costs associated with Medicaid-eligible individuals who are uninsured for the service are allowable under this population, assuming the service meets all other criteria outlined in this protocol, including but not limited to being “medically necessary.”

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<sup>4</sup> Community Based Detoxification Centers are the only provider type subject to the cost limit that does not submit the Medicare 2552 cost report.

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

Additionally, costs associated with the Medicaid-eligible population must not be duplicative of the uninsured individual costs.

The costs incurred for providing the services below are approved by CMS as additional allowable services not otherwise captured and/or allocated to the Medicaid-eligible and uninsured population through the CMS 2552 allocation method.

For the purposes of the UCCR, a Massachusetts Medicaid Managed Care Organization (otherwise referred to as “MMCO”) includes MCOs, Integrated Care Organizations (ICOs), Senior Care Organizations (SCOs), Programs of All-inclusive Care for the Elderly (PACE), and Prepaid Inpatient or Ambulatory Health Plan (including the behavioral health PIHP).

<b>Cost Element</b>	<b>Inpatient Services</b>	<b>Outpatient Hospital Services</b>	<b>Chronic Disease and Rehab – Inpatient</b>	<b>Chronic Disease and Rehab – Outpatient</b>	<b>Psychiatric Inpatient Hospital</b>	<b>Psychiatric Outpatient Hospital</b>	<b>Substance Abuse Treatment – Inpatient</b>	<b>Substance Abuse Treatment – Outpatient</b>
Professional component of provider-based physician costs, including contracted physician costs, which are not part of the inpatient hospital billing	X	X	X	X	X	X		
Provider component of provider-based physician costs reduced by Medicare reasonable compensation equivalency (RCE) limits, subject to applicable Medicare cost principles	X	X	X	X	X	X		
Administrative costs of the hospital’s billing activities	X	X	X	X	X	X		

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

Cost Element	Inpatient Services	Outpatient Hospital Services	Chronic Disease and Rehab – Inpatient	Chronic Disease and Rehab – Outpatient	Psychiatric Inpatient Hospital	Psychiatric Outpatient Hospital	Substance Abuse Treatment – Inpatient	Substance Abuse Treatment – Outpatient
associated with physician services who are employees of the hospital billed and received by the hospital								
Patient and community education programs, excluding cost of marketing activities	X	X	X	X	X	X	X	X
Telemedicine services	X	X	X	X	X	X	X	X
Addiction Services	X	X	X	X	X	X		X
Community Psychiatric Support and Treatment		X		X		X		X
Medication Administration		X				X		
Vision Care		X						
Health care for the house bound and the homeless, family planning, and pre-natal, labor, and post-natal support for at risk pregnancies. CMS 255-10, Line 193		X						
Social, Financial, Interpreter, Coordinated Care and other services for Medicaid-eligible and	X	X	X	X	X	X	X	X

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

Cost Element	Inpatient Services	Outpatient Hospital Services	Chronic Disease and Rehab – Inpatient	Chronic Disease and Rehab – Outpatient	Psychiatric Inpatient Hospital	Psychiatric Outpatient Hospital	Substance Abuse Treatment – Inpatient	Substance Abuse Treatment – Outpatient
uninsured patients								
340b and other pharmacy costs		X						
Graduate Medical Education	X	X	X	X	X	X		
Outlier Day: Each day beyond 20 acute days, during a single admission, for which a member remains hospitalized at acute status	X							
Psychiatric Day Treatment Program Services		X				X		
Dental Services		X						
Intensive Early Intervention Services for Children with Autism Spectrum Disorder	X	X						
Diversionsary Behavioral Health Services	X	X	X	X	X	X	X	X
Public Hospital Pensions and Retiree Benefits	X	X						

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

**UCCR Instructions**

Schedule A: Computation of MassHealth Fee-for-Service (FFS) Costs

*Column 1 – Reported Costs*

Enter costs from the hospital's most recently filed Medicare cost report (CMS 2552) Worksheet B, Part 1, column 24. This column includes costs that have already been reclassified, adjusted and stepped down through the A and B worksheet series and includes costs related to interns and residents.

*Column 2 – Reclassification of Observation Costs and Inclusion of Post-Stepdown Costs*

Reclassify observation costs from Line 30 to Line 92. The observation costs are derived from the CMS-2552, Worksheet C, Part I, Column 5, Line 92.

Add post-step-down costs from Supplemental Worksheet B-2, Column 4, Lines 54, 60, 89 & 90, except costs related to interns and residents.

For line 30 (Adults and Pediatrics), include a decreasing adjustment, if applicable, for the swing bed costs reported on Worksheet D-1, Part I, line 26, and for the private room differential costs reported on Worksheet D-1, Part I, line 36.

*Column 3 – Total Costs*

Sum of costs from column 1 and column 2. [This column will auto-populate.]

*Column 4 – Charges*

Enter charges from the hospital's most recently filed Medicare cost report (CMS 2552) Worksheet C, Part I, column 8.

*Column 5 – Hospital Cost-to-Charge Ratios*

Calculate the cost-to-charge ratio for each cost center by dividing the total costs for each cost center from column 3 by the respective charges from column 4. [This column will auto-populate.]

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

*Column 6* – Total MassHealth Fee-for-Service Inpatient Charges:

Enter from hospital records inpatient charges by cost center related to MassHealth Fee-for-Service (FFS) patients.

- MassHealth FFS Charges include only those charges for the following:
  - Medically necessary services as defined in 130 CMR 450.204;
  - MassHealth covered inpatient hospital services provided to MassHealth patients eligible pursuant to Titles XIX and XXI at the time of service delivery.
  
- MassHealth FFS Charges may not include:
  - Charges associated with services provided to MassHealth members where the service is covered by a Medicaid Managed Care Organization;
  - Charges associated with claims that have been final denied for payment by MassHealth;
  - Charges associated with state programs that are not Title XIX and Title XXI programs (e.g., the Children’s Medical Security Plan);
  - Charges associated with the professional component of hospital-based physician services.

*Column 7* – MassHealth FFS Inpatient Costs

For Lines 50 through 117, calculate the MassHealth FFS inpatient costs by multiplying for each cost center the MassHealth FFS inpatient charges from column 8 by the respective hospital cost-to-charge ratios from column 5. [These lines will auto-populate.] For lines 30-46, costs are determined using a per diem methodology; these cells will automatically be populated after Schedule B (column 5) has been completed.

*Column 8* – MassHealth Fee-for-Service Outpatient Charges

Enter from hospital records outpatient charges by cost center related to MassHealth Fee-for-Service (FFS) patients.

- MassHealth FFS Outpatient Charges include only those charges for the following:
  - Medically necessary services as defined in 130 CMR 450.204;

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

- MassHealth covered outpatient hospital services provided to MassHealth patients eligible pursuant to Titles XIX and XXI at the time of service delivery.
- MassHealth FFS Outpatient Charges may not include:
  - Charges associated with services provided to MassHealth members where the service is covered by a Medicaid Managed Care Organization;
  - Charges associated with claims that have been final denied for payment by MassHealth;
  - Charges associated with state programs that are not Title XIX or Title XXI programs (e.g., the Children’s Medical Security Plan);
  - Charges associated with the professional component of hospital-based physician services.

*Column 9 – MassHealth Fee-for-Service Outpatient Costs*

MassHealth FFS outpatient costs are determined by multiplying the MassHealth outpatient charges for each cost center from column 8 by the respective hospital cost-to-charge ratios from column 5. [This column will auto-populate.]

*Column 10 – Total MassHealth Fee-for-Service Inpatient and Outpatient Costs*

Total MassHealth FFS costs are determined by adding the MassHealth inpatient costs from column 7 and the MassHealth outpatient costs from column 11. [This column will auto-populate.]

Schedule B: Computation of Inpatient Routine Cost Center Per Diems

For the purposes of completing Schedule B, patient days entered in Columns 2, 4, 6 and 8 must include only those days wherein a patient fully met, at the time of service, the criteria for the given category (FFS, MMCO, HSN and Uninsured Care), as set forth in the Instructions to Schedules A and C.

*Column 1 – Total Routine Cost Center Inpatient Costs*

Enter total costs for each routine cost center as reported on UCCR Schedule A, Column 3, lines 30-46. [This column will auto-populate.]



**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

*Column 2 – Total Inpatient Days*

Enter total patient days for each routine cost center from CMS-2552 Worksheet S-3, Part 1, Column 8.

*Column 3 – Per Diem*

Calculate the average cost per day (per diem) by dividing total costs for each cost center in column 1 by the respective total patient days in column 2. [This column will auto-populate.]

*Column 4 – MassHealth Fee-for-Service Inpatient Days*

Enter total MassHealth FFS inpatient days for each routine cost center on lines 30-46 from provider records.

*Column 5 – Total MassHealth FFS Inpatient Costs*

Calculate total FFS inpatient costs for each routine cost center by multiplying the days in column 4 by the per diem in column 3. [This column will auto-populate.]

*Column 6 – Medicaid Managed Care Inpatient Days*

Enter total MassHealth managed care inpatient days for each routine cost center on lines 30-46 from provider records.

*Column 7 – Total Medicaid Managed Care Inpatient Costs*

Calculate total MMCO inpatient costs for each routine cost center by multiplying the days in column 6 by the per diem in column 3. [This column will auto-populate.]

*Column 8 – HSN and Uninsured Care Inpatient Days*

Enter total HSN and Uninsured Care inpatient days for each routine cost center on lines 30-46 from provider records.

*Column 9 – Total HSN and Uninsured Care Inpatient Costs*

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

Calculate total HSN and Uninsured Care inpatient costs for each routine cost center by multiplying the days in column 8 by the per diem in column 3. [This column will auto-populate.]

Schedule C: Computation of Massachusetts Medicaid Managed Care (MMCO) and HSN and Uninsured Costs

For the purposes of completing Schedule C:

- Massachusetts Medicaid Managed Care Charges include only those charges for the following:
  - Medically necessary services as defined in 130 CMR 450.204;
  - MassHealth covered inpatient and outpatient hospital services provided to MassHealth patients eligible pursuant to Titles XIX and XXI and enrolled in a MassHealth contracting MCO, SCO, PACE, PIHP and PAHP (MMCO) at the time of service delivery.
  
- Medicaid Managed Care Charges may not include:
  - Charges associated with services provided to MassHealth members where the service is covered under MassHealth Fee-for-Service, including the Primary Care Clinician program;
  - Charges associated with claims that have been final denied for payment by the MMCO;
  - Charges associated with state programs that are not Title XIX and Title XXI programs (e.g., the Children's Medical Security Plan);
  - Charges associated with patients eligible for another state's Medicaid program;
  - Charges reported as HSN and Uninsured Care (below).
  
- HSN and Uninsured Care Inpatient and Outpatient Charges are defined as those charges associated with care provided by hospitals for medically necessary services, including services reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity provided to:
  - Individuals with no health insurance coverage;
  - Low-Income Patients (under state regulation 114.6 CMR 12.03 (3) or (4) or its successor regulation) with no health insurance coverage;
  - Low-Income Patients (under state regulation 114.6 CMR 12.03 (3) or (4) or its successor regulation) whose public or private health

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

- insurance plan does not cover the cost of the particular service (excluding unpaid coinsurance and/or deductible amounts); or
- Medicaid-eligible patients whose medical service is not paid by MassHealth or the Massachusetts Medicaid Managed Care Organizations, SCO, ICO, PACE, PIHP or PAHP;
- HSN and Uninsured Care Charges, for the purpose of Schedule C of the UCCR, shall exclude charges associated with:
  - Professional component of physician charges;
  - Overhead charges related to physician services.

*Column 1 – Hospital Cost-to-Charge Ratios*

Enter the hospital cost-to-charge ratio for each cost center from Schedule A: MassHealth Fee-for-Service (FFS) Costs column 5. [This column will auto-populate.]

*Column 2 – Massachusetts Medicaid Managed Care Inpatient Charges*

Enter from hospital records inpatient charges, by cost center, related to Massachusetts Medicaid managed care patients.

*Column 3 – Massachusetts Medicaid Managed Care Inpatient Costs*

Massachusetts Medicaid managed care inpatient costs are determined by multiplying the Massachusetts Medicaid managed care inpatient charges for each cost center from column 2 by the respective hospital cost-to-charge ratios from column 1. However, for lines 30-46, costs are determined using a per diem methodology via Schedule B. [This column will auto-populate.]

*Column 4 – Massachusetts Medicaid Managed Care Outpatient Charges*

Enter from hospital records outpatient charges, by cost center, related to Massachusetts Medicaid managed care patients.

*Column 5 – Massachusetts Medicaid Managed Care Outpatient Costs*

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

Massachusetts Medicaid managed care outpatient costs are determined by multiplying the Massachusetts Medicaid managed care outpatient charges for each cost center from column 4 by the respective hospital cost-to-charge ratios from column 1.

*Column 6* – Total Massachusetts Medicaid managed care Inpatient and Outpatient Costs

Total Massachusetts Medicaid managed care inpatient and outpatient costs are determined by adding the Massachusetts Medicaid managed care inpatient costs from column 3 and the Massachusetts Medicaid managed care outpatient costs from column 5.

*Column 7* – HSN and Uninsured Care Inpatient Charges

Enter from hospital records inpatient charges, by cost center, related to HSN and Uninsured Care patients.

*Column 8* – HSN and Uninsured Care Inpatient Costs

For Lines 50 through 117, HSN and Uninsured Care inpatient costs are determined by multiplying the HSN and Uninsured Care inpatient charges for each cost center from column 7 by the respective hospital cost-to-charge ratios from column 1; for lines 30-46, costs are determined using a per diem methodology via Schedule B. [This column will auto-populate through line 94.]

*Column 9* – HSN and Uninsured Care Outpatient Charges

Enter from the hospital records outpatient charges by cost center related to HSN and Uninsured Care patients.

*Column 10* – HSN and Uninsured Care Outpatient Costs

HSN and Uninsured Care outpatient costs are determined by multiplying the HSN and Uninsured Care outpatient charges for each cost center from column 9 by the respective hospital cost-to-charge ratios from column 1.

*Column 11* – Total HSN and Uninsured Care Inpatient and Outpatient Costs

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

Total HSN and Uninsured Care inpatient and outpatient costs are determined by adding the HSN and Uninsured Care inpatient costs from column 8 and the HSN and Uninsured Care outpatient costs from column 10.

Schedule D: Computation of Uncompensated Physician Costs

For purposes of completing Schedule D:

Uncompensated Physician Costs are limited to those charges incurred by hospital-based physicians for professional services.

- MassHealth FFS Inpatient and Outpatient Charges include only those charges for the following:
  - Medically necessary services as defined in 130 CMR 450.204;
  - MassHealth covered hospital-based physician professional services provided to MassHealth patients eligible pursuant to Titles XIX and XXI at the time of service delivery.
  - Charges associated with the professional component of hospital-based physician services.
  
- MassHealth FFS Hospital-Based Physician Professional Charges may not include:
  - Charges associated with services provided to MassHealth members where the service is covered by a Medicaid Managed Care Organization;
  - Charges associated with claims that have been final denied for payment by MassHealth;
  - Charges associated with state programs that are not Title XIX and Title XXI programs (e.g., the Children's Medical Security Plan);
  
- Massachusetts Medicaid Managed Care Charges include only those charges for the following:
  - Medically necessary services as defined in 130 CMR 450.204;
  - MassHealth covered hospital-based physician services provided to MassHealth patients eligible pursuant to Titles XIX and XXI and enrolled in a MassHealth contracting MCO, SCO, PACE, PIHP and PAHP (MMCO) at the time of service delivery.
  
- Medicaid Managed Care Charges may not include:
  - Charges associated with services provided to MassHealth members where the service is covered under MassHealth Fee-for-Service, including the Primary Care Clinician program;

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

- Charges associated with claims that have been final denied for payment by the MMCO;
  - Charges associated with state programs that are not Title XIX and Title XXI programs (e.g., the Children’s Medical Security Plan);
  - Charges reported as HSN and Uninsured Care (below).
- HSN and Uninsured Care Physician Charges are defined as those physician charges associated with care provided for medically necessary services, including services reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity provided to:
    - Individuals with no health insurance coverage;
    - Low-Income Patients (under state regulation 114.6 CMR 12.03 (3) or (4) or its successor regulation) with no health insurance coverage;
    - Low-Income Patients (under state regulation 114.6 CMR 12.03 (3) or (4) or its successor regulation) whose public or private health insurance plan does not cover the cost of the particular service (excluding unpaid coinsurance and/or deductible amounts); or
    - Medicaid-eligible patients whose medical service is not paid by MassHealth or the Massachusetts Medicaid Managed Care Organizations, SCO, ICO, PACE, PIHP or PAHP;

*Column 1 – Professional Component of Physicians’ Costs*

The professional component of physicians’ costs come from the hospital’s most recently filed Medicare cost report (CMS 2552) Worksheet A-8-2, column 4.

*Column 2 – Overhead Costs Related to Physicians’ Services*

If the overhead costs related to physicians’ services were adjusted out of the physicians’ costs entered on Worksheet A-8-2, enter those overhead costs from Worksheet A-8 to the corresponding cost center.

*Column 3 – Total Physicians’ Costs*

Total Physicians’ costs are determined by adding column 1 and column 2. [This column will auto-populate.]

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

*Column 4* – Total Physician Inpatient and Outpatient Charges

Enter the total charges related to physician inpatient and outpatient services from hospital records to the corresponding cost center.

*Column 5* – Cost-to-Charge Ratios

For each cost center, a cost-to-charge ratio is calculated by dividing total physicians' costs in column 3 by total physician charges in column 4. [This column will auto-populate.]

*Column 6* – MassHealth FFS Physician Inpatient and Outpatient Charges

Enter by cost center the total charges related to physician inpatient and outpatient services for MassHealth FFS patients from hospital records.

*Column 7* – MassHealth FFS Physician Inpatient and Outpatient Costs

MassHealth FFS physician inpatient and outpatient costs are determined for each cost center by multiplying the MassHealth FFS inpatient and outpatient physician charges from column 6 by the cost-to-charge ratio from column 5. [This column will auto-populate.]

*Column 8* – Massachusetts Medicaid Managed Care Physician Inpatient and Outpatient Charges

Enter the total charges related to physician inpatient and outpatient services for Massachusetts Medicaid managed care patients from hospital records.

*Column 9* – Massachusetts Medicaid Managed Care Physician Inpatient and Outpatient Costs

Massachusetts Medicaid managed care physician inpatient and outpatient costs are determined for each cost center by multiplying the Massachusetts Medicaid managed care inpatient and outpatient physician charges from column 8 by the cost-to-charge ratio from column 5. [This column will auto-populate.]

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

*Column 10* – HSN and Uninsured Care Physician Inpatient and Outpatient Charges

From provider records, enter the charges related to physician inpatient and outpatient services for HSN and Uninsured Care patients as defined above.

*Column 11* – HSN and Uninsured Care Physician Inpatient and Outpatient Costs

HSN and Uninsured Care physician inpatient and outpatient costs are determined for each cost center by multiplying the HSN and Uninsured Care inpatient and outpatient physician charges from column 10 by the cost-to-charge ratio from column 5. [This column will auto-populate.]

*Column 12* – Total Massachusetts Medicaid Fee For Service Medicaid Managed Care and HSN and Uninsured Care Inpatient and Outpatient Physician Costs

Total Massachusetts Medicaid fee for service, managed care and HSN and Uninsured Care inpatient and outpatient physician costs are determined by adding column 7, column 9 and column 11.

Schedule E: Safety Net Health Care System (SNCHS) Expenditures

Pursuant to Section 49 (c) of the 1115 demonstration Special Terms and Conditions, expenditures for payments to providers is authorized under the safety net care pool to support uncompensated care for “Medicaid FFS, Medicaid managed care, and low-income uninsured individuals.” This Schedule E provides health care providers the opportunity to itemize such system expenditures for the Medicaid-eligible and uninsured population and includes the additional allowable costs outlined in the Development Tool approved by CMS on September 6, 2013 and any additional allowable costs described in the Cost Element table of this document.

*Column 1* – Total SNHCS Expenditures

Enter total safety net health care system expenditures for each line item.

*Column 2* – Medicaid-eligible / HSN and Uninsured Payer Mix Proportion

To determine the proportion of total system expenditures attributable to Medicaid-eligible and uninsured patients, first estimate the total charges for the year attributable to this group; next, estimate the total charges for the year attributable to all patients



**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

served by the SNHCS. The ratio of these two numbers will be used to estimate the amount of system expenditures attributable to Medicaid-eligible and uninsured patients. Enter this ratio in column 2. Should an alternative ratio be more appropriate, enter that number, and then explain the basis for it in the Narrative Description section of Schedule E.

*Column 3 – Medicaid-eligible / HSN and Uninsured Share of System Expenditures*

Calculate the system expenditures attributable to Medicaid-eligible and uninsured patients by multiplying the total system expenditure in column 1 by the payer mix proportion in column 2. [This column will auto-populate.]

Schedule F: Medicaid and Uninsured Revenue

Note: Hospitals must ensure that any applicable revenues pertaining to Medicaid or uninsured costs allowed in Schedule E are captured in Schedule F and are treated as an offset to arrive at net uncompensated care costs.

Line Instructions:

Hospital and Clinic Revenue:

In lines 1-8, enter amounts paid for services provided by the hospital and any provider-based satellites, including hospital-licensed health centers.

Line 1 – Payer Medical Claims Revenue

For each column, enter in line 1 the total amount paid by the payer for medical claims. Do not include payments for that are not related to claims, such as pay-for-performance payments or supplemental payments. The amounts reported must reflect any post-payment reconciliations or recoupments, subject to the availability of that data.

Column 5 - Health Safety Net and Uninsured

In line 1, column 5, report the gross payments received from the HSN and Uninsured. Do not offset the amount of the HSN Assessment.

Line 2 – Pay for Performance / Incentive Payment Revenue

This revenue data is reported for informational purposes only. Payments that are not service payments for the provision of medical care are not offset against the eligible cost. Since following payments are not payments for the provision of medical care,

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

they are not offset against the eligible cost: SNCP grants and performance-based, incentive, and shared savings payments. These include performance-based and incentive-based payments and grants and awards both currently in existence and those that may be approved and implemented during future demonstration renewal periods.

Enter in line 2 any amounts paid by the payer for pay-for-performance or other incentive payments. The amount reported must also include any recoveries made by the payer for performance issue, such as retrospective performance penalties.

**Line 3-5 – Supplemental Payments**

Enter in lines 3-5 any amounts paid by the payer for supplemental payments. Specify the type of supplemental payment reported by modifying the title of the line. The total gross payment must be reported; do not offset any payment amount by any intergovernmental transfer amounts that may have been made by a related public entity.

**Line 6 – Medicare Revenue**

Enter in line 6 any payments amounts received by Medicare for services provided to patients who are eligible for both Medicare and the payer noted in the column.

**Line 7 – Third Party and Self Pay Revenue**

Enter in line 7 any payment amounts received by third parties, the patient, or the patient's guarantor for the cost-sharing or services not covered by the payer noted in the column.

**Line 8 – Other Revenue**

Enter in line 8 any additional revenue from the payer for the Medicaid-eligible and uninsured populations not included in lines 1-7. Specify the type of revenue by modifying the title of the line. Additional information may be provided in the Notes tab.

**Line 9 – Subtotal Hospital and Clinic**

Sum of lines 1-8. [This line will auto-populate.]

**Lines 10-15 Physician Revenue**

Using the same descriptions in the corresponding lines 1-8, report physician revenue related to the payers.

**Line 16 – Subtotal Physician Revenue**

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

Sum of lines 10-15. [This line will auto-populate.]

Line 17 – Total Revenue.

Sum of lines 9 and 16. [This line will auto-populate.]

Column Instructions.

*Column 1 – Medicaid FFS Inpatient Revenue*

Report in column 1, amounts paid by MassHealth for inpatient services provided to members enrolled in the MassHealth program, excluding those enrolled in MassHealth managed care programs.

*Column 2 – Medicaid FFS Outpatient Revenue*

Report in column 2, amounts paid by MassHealth for outpatient services provided to members enrolled in the MassHealth program, excluding those enrolled in MassHealth managed care programs.

*Column 3 – Medicaid Managed Care Inpatient Revenue*

Report in column 3, amounts paid by Medicaid Managed Care Organizations for inpatient services provided to members.

*Column 4 – Medicaid Managed Care Outpatient Revenue*

Report in column 4, amounts paid by Medicaid Managed Care Organizations for outpatient services provided to members.

*Column 5 – HSN and Uninsured Inpatient and Outpatient Revenue*

Report in column 5, amounts paid by the HSN and Uninsured individuals for inpatient and outpatient services provided. Report the gross payments received from the HSN. Do not offset the amount of the HSN Assessment.

*Column 6 – Total Revenue*

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

Sum of columns 1 through 5. [This column will auto-populate.]

Schedule G: Notes

Providers may use Schedule G to provide additional information on the data reported.

**IV. Reconciliation**

Interim Reconciliation

Each provider's uncompensated care costs must be computed based on the provider's as-filed CMS 2552<sup>5</sup> cost report and Uniform Medicaid & Uncompensated Care Cost & Charge Report (UCCR) and for the actual service period. The CMS 2552 cost report is filed with the Medicare contractor five months after the close of the cost reporting period. The UCCR must be filed three months after the CMS 2552 is filed. For SNCP payments subject to the cost limit pursuant to STC 49(c), each provider's allowable Medicaid, uncompensated care, and uninsured costs must be reconciled against associated applicable payments received for the year for which the payments were made.

For hospitals whose accounting fiscal year aligns with the cost limit reporting fiscal year (Federal fiscal year), the Medicaid and uninsured costs will be reflected in the CMS 2552 and UCCR that is submitted for the accounting fiscal year. For acute hospitals whose accounting fiscal years do not align with the reporting fiscal year, the reporting year cost limit will be calculated by applying the appropriate percentage of the two contiguous CMS 2552 and UCCR cost reports that span the reporting fiscal year so that the Federal fiscal year will be represented in the cost limit calculation.

The Commonwealth must recover provider overpayments as it determines necessary based on its reconciliation calculations and availability of federal financial participation.

Specifically, if an overpayment exists, the Commonwealth must determine if the overpayment occurred due to Health Safety Net (HSN) Trust Fund payments or other SNCP payments, or from both payments. To the extent that the overpayment is a result of overpaid funds from the HSN Trust Fund, the Commonwealth must recover from the provider the amount overpaid to the provider from the HSN Trust Fund and credit that amount to the HSN Trust Fund. The HSN Trust Fund will redistribute such amounts to other providers as appropriate. To the extent that the overpayment is not

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<sup>5</sup> Community Based Detoxification Centers are the only provider type subject to the cost limit that does not submit the CMS 2552 cost report.

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

the result of HSN Trust Fund payments, the Commonwealth must recover from the provider the overpayment, and the Commonwealth must properly credit the federal share to the federal government.

The interim reconciliation described above must be performed and completed within twelve months after the filing of the Medicare cost report(s).

Final Reconciliation

Each provider's uncompensated care costs must be recomputed based on the provider's audited CMS 2552 cost report for the actual service period. These recomputed costs must be carried over to the UCCR. The CMS 2552 cost report is audited and settled by the Medicare contractor to determine final allowable costs and reimbursement amounts as recognized by Medicare. For SNCP payments subject to the cost limit pursuant to STC 49(c), each provider's allowable Medicaid, uncompensated care, and uninsured costs must be reconciled against associated applicable payments received for the year for which the payments were made. SNCP uncompensated care payments made to the provider for a cost limit reporting year cannot exceed the recomputed uncompensated care cost limit. If, at the end of the final reconciliation process, it is determined that expenditures claimed exceeded the individual provider's uncompensated care cost limit, thereby causing an overpayment, the Commonwealth must recoup the overpayment from the provider. Specifically, if an overpayment exists, the Commonwealth must determine if the overpayment occurred due to HSN Trust Fund payments or other SNCP payments, or from both payments. To the extent that the overpayment is a result of overpaid funds from the HSN Trust Fund, the Commonwealth must recover from the provider the amount overpaid to the provider from the HSN Trust Fund and credit that amount to the HSN Trust Fund. The HSN Trust Fund will redistribute such amounts to other providers as appropriate. To the extent that the overpayment is not the result of HSN Trust Fund payments, the Commonwealth must recover from the provider the overpayment, and the Commonwealth must properly credit the federal share to the federal government.

For hospitals whose accounting fiscal year aligns with the cost limit reporting fiscal year (Federal fiscal year), the Medicaid and uninsured costs will be reflected in the CMS 2552 and UCCR that is submitted for the accounting fiscal year. For acute hospitals whose accounting fiscal years do not align with the reporting fiscal year, the reporting year cost limit will be calculated by applying the appropriate percentage of the two contiguous CMS 2552 and UCCR cost reports that span the reporting fiscal year so that the Federal fiscal year will be represented in the cost limit calculation.

The Commonwealth must recover provider overpayments as it determines necessary based on its reconciliation calculations and availability of federal financial participation.

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

The final reconciliation described above must be performed and completed within twelve months after all final, audited CMS 2552 cost reports become available online.

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

**Institutions for Mental Diseases – Psychiatric Hospitals and Community Based  
Detoxification Centers (CBDCs) Protocol for Medicaid and Uncompensated Care  
Cost**

The Commonwealth will use the reports described below to collect data from these providers.

Psychiatric hospitals will fill out the CMS 2552 and UCCR, as required of other hospitals in the cost limit protocol. CBDCs are non-hospital human and social services contractors that do not file a CMS 2552 cost report; therefore, for the purposes of the protocol, the Commonwealth will use only the Massachusetts **Uniform Financial Statements and Independent Auditor’s Report (UFR)** to determine costs and revenues. The UFR is the set of financial statements and schedules required of human and social service contracting with state departments. For the calculation of provider-specific cost limits, psychiatric hospitals and CBDCs will fill out the necessary reports with the information that is relevant to the services they provide to the Medicaid-eligible and HSN and uninsured populations.

**Determination of Allowable Medicaid and Uninsured Costs**

- a. DSH Allowable Costs
  - i. Per STC 50(f), the Commonwealth will use the Medicaid DSH statutory, regulatory, and policy definitions of allowable psychiatric hospital services and allowable Medicaid and uninsured costs in determining hospital-specific cost limits in its cost protocols. To the extent that the determination of uncompensated care costs varies from the Medicaid DSH requirements, the process must be accounted for in this document.
  - ii. Pharmacy service costs are separately identified on the CMS 2552 10 cost report and are not recognized as an inpatient or outpatient hospital service. Pharmacy service costs that are not part of an inpatient or outpatient rate and are billed as pharmacy service and reimbursed as such are not considered eligible for inclusion in the hospital-specific uncompensated cost limit allowable under DSH. To the extent that the determination of allowable pharmacy costs varies from the Medicaid DSH requirements, the process must be accounted for in this document.
  - iii. Costs included must be for services that meet the federal definition and the approved Massachusetts State plan definition of “hospital services” for medical assistance. “Medical assistance” is defined as the cost of care and services “for individuals, and, with respect to physicians’ or dentists’ services, at the option of the State, to individuals [who are eligible]...” Section 1905 of the Act.

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

- b. Medicaid State Plan Allowable Costs
  - i. Massachusetts must use the same definition for all inpatient hospital, outpatient hospital, and physician services, clinic services, non-hospital services, etc. as described in its approved Medicaid State plan, and in accordance with Section 1905 of the Social Security Act and the regulations promulgated thereunder, to define allowable service costs provided by institutions for mental disease. Massachusetts identifies other service costs, subject to CMS approval, that are not included in the Medicaid state plan definitions to be included as allowable uncompensated care costs in this document (see Cost Element table).
    - 1. Inpatient psychiatric hospital services: Psychiatric treatment provided under the direction of a psychiatrist in a psychiatric inpatient hospital. Such services are as described in Section 1905 of the Social Security Act and the regulations promulgated thereunder.
    - 2. Outpatient psychiatric hospital services: Services provided to members on an outpatient basis in a psychiatric hospital. Such services are as described in Section 1905 of the Social Security Act and the regulations promulgated thereunder.
    - 3. Community Based Detoxification Center (CBDC): CBDCs are eligible to receive Safety Net Care Pool payments as Institutions for Mental Diseases (IMDs) under the section 1115 demonstration. Such services are as described in Section 1905 of the Social Security Act and the regulations promulgated thereunder.
      - a. Acute Inpatient Substance Abuse Treatment Services: Short-term medical treatment for substance withdrawal, individual medical assessment, evaluation, intervention, substance abuse counseling, and post detoxification referrals provided by an inpatient unit, either freestanding or hospital-based, licensed as an acute inpatient substance abuse treatment service by the Massachusetts Department of Public Health under its regulations at 105 CMR 160.000 and 161.000. These services are delivered in a three-tiered system consisting of Levels III-A through III-C that must conform with the standards and patient placement criteria issued and enforced by the Massachusetts Department of Public Health's Bureau of Substance Abuse Services.
      - b. Substance Abuse Outpatient Counseling Service: An outpatient counseling service that is a



**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

rehabilitative treatment service for individuals and their families experiencing the dysfunctional effects of the use of substances.

- ii. 1115 Demonstration Population Expenditures: Costs incurred by psychiatric hospitals and CBDCs for providing IMD services to members eligible for Medicaid through the State plan and section 1115 demonstration will be counted as allowable costs. Allowable costs for psychiatric hospital services and CBDC services provided under the 1115 demonstration include service-related expenditures (please note that all services authorized under the section 1115 demonstration are subject to the requirements and limitations specified in the STCs). The list of allowable services is contained in the Cost Element table.
  - 1. Diversionary Behavioral Health Services
- c. Medicaid Managed Care Costs: Costs incurred by IMDs for providing services to members enrolled in Medicaid managed care organizations including SCOs and ICOs, prepaid inpatient health plans, and any prepaid ambulatory health plans. Eligible costs are determined using the same methodology under this section.
- d. Other Allowable Costs, Approved 1915(c) Waivers. The list of allowable services in contained in the Cost Element table.
- e. Additional Allowable Costs – The list of allowable services is contained in the Cost Element table.

**I. Summary of 2552-10 Cost Report (Psychiatric Hospitals Only)**

Worksheet A: Reclassification and Adjustment of Trial Balance of Expenses

Worksheet A provides for recording the trial balance of expense accounts from your accounting books and records. It also provides for the necessary reclassifications and adjustments to certain accounts. Not included on Worksheet A are items that conflict with Medicare regulations, manuals, or instructions but which providers may wish to claim and contest.

The trial balance of expenses is broken down into the following categories to facilitate the transfer of costs to the various worksheets:

- 1) General service cost centers
- 2) Inpatient routine service cost centers
- 3) Ancillary service cost centers
- 4) Outpatient service cost centers
- 5) Other reimbursable cost centers
- 6) Special purpose cost centers
- 7) Other special purpose cost centers not previously identified

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

- 8) Costs applicable to nonreimbursable cost centers to which general service costs apply
- 9) Nonreimbursable cost center to accumulate the cost incurred by you for services related to the physicians' private practice

Worksheet B

Worksheet B allocates overhead (originally identified as general service cost centers) to all other cost centers, including the non-reimbursable costs identified in lines 96 through 100.

Cost finding is the process of recasting data derived from the accounts ordinarily kept by the provider to ascertain costs of the various types of services rendered; i.e., the allocation of the expenses of each general service cost center to those cost centers which receive the services. The CMS 2552 approved method of cost finding is recognized and outlined in 42 CFR 413.24 and is based on the accrual basis of accounting except where government institutions operate on a cash basis of accounting.

Worksheet C

Worksheet C computes the ratio of cost to charges (RCC) for inpatient services, ancillary services, outpatient services, and other reimbursable services. The total cost for each cost center is derived from Worksheet B after the overhead allocation, and the total charge for each cost center is determined from the provider's records. This RCC is used on Worksheet D, Worksheet D-3, Worksheet D-4, Worksheet H-3, and Worksheet J-2 to determine the program's share of ancillary service costs in accordance with 42 CFR 413.53. This worksheet is also needed to determine the adjusted total costs used on Worksheet D-1.

Worksheet D

This series of worksheets is where the total costs from Worksheet B are apportioned to different payer programs. Apportionment is the process by which a cost center's total cost is allocated to a specific payer or program or service type. Apportionment is used to arrive at Medicare hospital inpatient routine and ancillary cost and Medicare hospital outpatient cost, etc.

Worksheet D consists of the following five parts:

- 1) Part I: Apportionment of Inpatient Routine Service Capital Costs
- 2) Part II: Apportionment of Inpatient Ancillary Service Capital Costs
- 3) Part III: Apportionment of Inpatient Routine Service Other Pass Through Costs
- 4) Part IV: Apportionment of Inpatient/Outpatient Ancillary Service Other Pass Through Costs
- 5) Part V: Apportionment of Medical and Other Health Services Costs

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

Worksheet D-1: All providers will complete this worksheet, which provides for the computation of hospital inpatient operating cost in accordance with 42 CFR 413.53 (determination of cost of services to beneficiaries), 42 CFR 413.40 (ceiling on rate of hospital cost increases), and 42 CFR 412.1 through 412.125 (prospective payment).

Worksheet D-2: Worksheet D-2 apportions the cost of services rendered by interns and residents across the following two parts:

- 1) Part I: Not in Approved Teaching Program. This part is used by the provider only if it has interns and residents that are not in an approved teaching program.
- 2) Part II: In an Approved Teaching Program (Title XVIII, Part B Inpatient Routine Costs Only). This part provides for reimbursement for inpatient routine services rendered by interns and residents in approved teaching programs to Medicaid beneficiaries.

Worksheet D-3: Worksheet D-3 apportions inpatient ancillary services.

Worksheet D-4: Worksheet D-4 computes organ acquisition costs and charges for hospitals that are certified transplant centers.

Worksheet D-5: Apportions cost for the services of teaching physicians.

Worksheet E

Worksheet E worksheets will be used to calculate Title XIX settlement for inpatient prospective payment system (IPPS) hospital services, medical and other health services.

**NOTES:**

For purposes of utilizing the CMS 2552 cost report to determine Medicare reimbursements, the term “as filed 2552 cost report” refers to the cost report filed on or before the last day of the fifth month following the close of the provider’s cost reporting period. The cost reporting period covers a 12-month period of operations based upon the provider’s accounting year.

**II. Uniform Medicaid & Uncompensated Care Cost & Charge Report (UCCR) (Psychiatric Hospitals Only)**

In relation to Medicaid reimbursement, the CMS 2552 report does not sufficiently capture costs for Massachusetts providers because costs cannot be allocated across other payers, nor are costs reimbursed through the CMS 2552 inclusive of those incurred for providing the types of services that support the Medicaid-eligible and

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

uninsured populations, such as those approved in this cost limit protocol as additional allowable costs.

The Commonwealth must use the CMS 2552<sup>6</sup> and Uniform Medicaid & Uncompensated Care Cost & Charge Report (UCCR) to determine Medicaid and uninsured costs. To supplement the Medicare 2552 cost report, hospitals subject to the cost protocol will file the UCCR to allocate allowable 2552 costs to Medicaid and uninsured services and, in accordance with the Cost Element table, recognize additional costs that are not otherwise reimbursed through the CMS 2552.

The UCCR report includes cost-center specific data by payer and its purpose is to capture uncompensated costs that safety net providers incur from supporting a large proportion of Medicaid-eligible and uninsured individuals. The UCCR also captures costs that are specifically allocated toward “funding required for the operation of the Safety Net Health Care System” on Schedule E, which was designed to reflect costs that are incurred disproportionately on behalf of Medicaid-eligible and uninsured patients (e.g., social, financial, and interpreter costs; unreimbursed costs for Dual Eligibles, etc. and other additional allowable costs approved in this cost limit protocol).

Overview

Psychiatric hospitals must submit cost, charge and patient day data via the UCCR, an electronic report developed by the Commonwealth, based on the CMS 2552, and currently used to record Medicaid and uncompensated care costs for certain safety net providers. For the Commonwealth’s use in calculating provider-specific uncompensated care cost limits, data submitted by the provider shall be based on information supplied on the hospital’s CMS 2552, as filed with and audited/settled by the Medicare fiscal intermediary, hospital records, and the UCCR.

NOTES:

The Medicaid-eligible population includes those individuals who are eligible for Medicaid but have private insurance; Medicaid FFS and Medicaid Managed Care, including individuals dually eligible for Medicaid and Medicare.

“Uninsured individuals” for whom uncompensated care costs are allowable includes the population for which HSN payments are made. Costs associated with Medicaid-eligible individuals who are uninsured for the service are allowable under this population, assuming the service meets all other criteria outlined in this protocol, including but not limited to being “medically necessary.”

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<sup>6</sup> Community Based Detoxification Centers are the only provider type subject to the cost limit that does not submit the CMS 2552 cost report.

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

Additionally, costs associated with the Medicaid-eligible population must not be duplicative of the uninsured individual costs.

The costs incurred for providing the services below are approved by CMS as additional allowable services not otherwise captured and/or allocated to the Medicaid-eligible and uninsured population through the CMS 2552 allocation method.

For the purposes of the UCCR, a Massachusetts Medicaid Managed Care Organization (otherwise referred to as “MMCO”) includes MCOs, Integrated Care Organizations (ICOs), Senior Care Organizations (SCOs), Programs of All-inclusive Care for the Elderly (PACE), and Prepaid Inpatient or Ambulatory Health Plan (including the behavioral health PIHP).

<b>Cost Element</b>	<b>Inpatient Services</b>	<b>Outpatient Hospital Services</b>	<b>Chronic Disease and Rehab – Inpatient</b>	<b>Chronic Disease and Rehab – Outpatient</b>	<b>Psychiatric Inpatient Hospital</b>	<b>Psychiatric Outpatient Hospital</b>	<b>Substance Abuse Treatment – Inpatient</b>	<b>Substance Abuse Treatment – Outpatient</b>
Professional component of provider-based physician costs, including contracted physician costs, which are not part of the inpatient hospital billing	X	X	X	X	X	X		
Provider component of provider-based physician costs reduced by Medicare reasonable compensation equivalency (RCE) limits, subject to applicable	X	X	X	X	X	X		

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

<b>Cost Element</b>	<b>Inpatient Services</b>	<b>Outpatient Hospital Services</b>	<b>Chronic Disease and Rehab – Inpatient</b>	<b>Chronic Disease and Rehab – Outpatient</b>	<b>Psychiatric Inpatient Hospital</b>	<b>Psychiatric Outpatient Hospital</b>	<b>Substance Abuse Treatment – Inpatient</b>	<b>Substance Abuse Treatment – Outpatient</b>
Medicare cost principles								
Administrative costs of the hospital's billing activities associated with physician services who are employees of the hospital billed and received by the hospital	X	X	X	X	X	X		
Patient and community education programs, excluding cost of marketing activities	X	X	X	X	X	X	X	X
Telemedicine services	X	X	X	X	X	X	X	X
Addiction Services	X	X	X	X	X	X		X
Community Psychiatric Support and Treatment		X		X		X		X
Medication Administration		X				X		
Vision Care		X						

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

Cost Element	Inpatient Services	Outpatient Hospital Services	Chronic Disease and Rehab – Inpatient	Chronic Disease and Rehab – Outpatient	Psychiatric Inpatient Hospital	Psychiatric Outpatient Hospital	Substance Abuse Treatment – Inpatient	Substance Abuse Treatment – Outpatient
Health care for the house bound and the homeless, family planning, and pre-natal, labor, and post-natal support for at risk pregnancies. CMS 255-10, Line 193		X						
Social, Financial, Interpreter, Coordinated Care and other services for Medicaid-eligible and uninsured patients	X	X	X	X	X	X	X	X
340b and other pharmacy costs		X						
Graduate Medical Education	X	X	X	X	X	X		
Outlier Day: Each day beyond 20 acute days, during a single admission, for which a member remains hospitalized at acute status	X							
Psychiatric Day		X				X		

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

Cost Element	Inpatient Services	Outpatient Hospital Services	Chronic Disease and Rehab – Inpatient	Chronic Disease and Rehab – Outpatient	Psychiatric Inpatient Hospital	Psychiatric Outpatient Hospital	Substance Abuse Treatment – Inpatient	Substance Abuse Treatment – Outpatient
Treatment Program Services								
Dental Services		X						
Intensive Early Intervention Services for Children with Autism Spectrum Disorder	X	X						
Diversionary Behavioral Health Services	X	X	X	X	X	X	X	X
Public Hospital Pensions and Retiree Benefits	X	X						

**UCCR Instructions**

Schedule A: Computation of MassHealth Fee-for-Service (FFS) Costs

*Column 1 – Reported Costs*

Enter costs from the hospital’s most recently filed Medicare cost report (CMS 2552) Worksheet B, Part 1, column 24. This column includes costs that have already been reclassified, adjusted and stepped down through the A and B worksheet series and includes costs related to interns and residents.

*Column 2 – Reclassification of Observation Costs and Inclusion of Post-Stepdown Costs*

Reclassify observation costs from Line 30 to Line 92. The observation costs are derived from the CMS-2552, Worksheet C, Part I, Column 5, Line 92.

Add post-step-down costs from Supplemental Worksheet B-2, Column 4, Lines 54, 60, 89 & 90, except costs related to interns and residents.



**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

For line 30 (Adults and Pediatrics), include a decreasing adjustment, if applicable, for the swing bed costs reported on Worksheet D-1, Part I, line 26, and for the private room differential costs reported on Worksheet D-1, Part I, line 36.

*Column 3 – Total Costs*

Sum of costs from column 1 and column 2. [This column will auto-populate.]

*Column 4 – Charges*

Enter charges from the hospital's most recently filed Medicare cost report (CMS 2552) Worksheet C, Part I, column 8.

*Column 5 – Hospital Cost-to-Charge Ratios*

Calculate the cost-to-charge ratio for each cost center by dividing the total costs for each cost center from column 3 by the respective charges from column 4. [This column will auto-populate.]

*Column 6 – Total MassHealth Fee-for-Service Inpatient Charges:*

Enter from hospital records inpatient charges by cost center related to MassHealth Fee-for-Service (FFS) patients.

- MassHealth FFS Charges include only those charges for the following:
  - Medically necessary services as defined in 130 CMR 450.204;
  - MassHealth covered inpatient hospital services provided to MassHealth patients eligible pursuant to Titles XIX and XXI at the time of service delivery.
  
- MassHealth FFS Charges may not include:
  - Charges associated with services provided to MassHealth members where the service is covered by a Medicaid Managed Care Organization;
  - Charges associated with claims that have been final denied for payment by MassHealth;
  - Charges associated with state programs that are not Title XIX and Title XXI programs (e.g., the Children's Medical Security Plan);

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

- Charges associated with the professional component of hospital-based physician services.

*Column 7 – MassHealth FFS Inpatient Costs*

For Lines 50 through 117, calculate the MassHealth FFS inpatient costs by multiplying for each cost center the MassHealth FFS inpatient charges from column 8 by the respective hospital cost-to-charge ratios from column 5. [These lines will auto-populate.] For lines 30-46, costs are determined using a per diem methodology; these cells will automatically be populated after Schedule B (column 5) has been completed.

*Column 8 – MassHealth Fee-for-Service Outpatient Charges*

Enter from hospital records outpatient charges by cost center related to MassHealth Fee-for-Service (FFS) patients.

- MassHealth FFS Outpatient Charges include only those charges for the following:
  - Medically necessary services as defined in 130 CMR 450.204;
  - MassHealth covered outpatient hospital services provided to MassHealth patients eligible pursuant to Titles XIX and XXI at the time of service delivery.
- MassHealth FFS Outpatient Charges may not include:
  - Charges associated with services provided to MassHealth members where the service is covered by a Medicaid Managed Care Organization;
  - Charges associated with claims that have been final denied for payment by MassHealth;
  - Charges associated with state programs that are not Title XIX or Title XXI programs (e.g., the Children’s Medical Security Plan);
  - Charges associated with the professional component of hospital-based physician services.

*Column 9 – MassHealth Fee-for-Service Outpatient Costs*

MassHealth FFS outpatient costs are determined by multiplying the MassHealth outpatient charges for each cost center from column 8 by the respective hospital cost-to-charge ratios from column 5. [This column will auto-populate.]

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

*Column 10* – Total MassHealth Fee-for-Service Inpatient and Outpatient Costs

Total MassHealth FFS costs are determined by adding the MassHealth inpatient costs from column 7 and the MassHealth outpatient costs from column 9. [This column will auto-populate.]

Schedule B: Computation of Inpatient Routine Cost Center Per Diems

For the purposes of completing Schedule B, patient days entered in Columns 2, 4, 6 and 8 must include only those days wherein a patient fully met, at the time of service, the criteria for the given category (FFS, MMCO, HSN and Uninsured Care), as set forth in the Instructions to Schedules A and C. The SNF, NF, and LTC cost centers must be removed from Schedule B, since these costs cannot be claimed as part of the hospital uncompensated care costs.

*Column 1* – Total Routine Cost Center Inpatient Costs

Enter total costs for each routine cost center as reported on UCCR Schedule A, Column 3, lines 30-46. [This column will auto-populate.]

*Column 2* – Total Inpatient Days

Enter total patient days for each routine cost center from CMS-2552 Worksheet S-3, Part 1, Column 8.

*Column 3* – Per Diem

Calculate the average cost per day (per diem) by dividing total costs for each cost center in column 1 by the respective total patient days in column 2. [This column will auto-populate.]

*Column 4* – MassHealth Fee-for-Service Inpatient Days

Enter total MassHealth FFS inpatient days for each routine cost center on lines 30-46 from provider records.

*Column 5* – Total MassHealth FFS Inpatient Costs

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

Calculate total FFS inpatient costs for each routine cost center by multiplying the days in column 4 by the per diem in column 3. [This column will auto-populate.]

*Column 6 – Medicaid Managed Care Inpatient Days*

Enter total Medicaid Managed Care inpatient days for each routine cost center on lines 30-46 from provider records.

*Column 7 – Total Medicaid Managed Care Inpatient Costs*

Calculate total MMCO inpatient costs for each routine cost center by multiplying the days in column 6 by the per diem in column 3. [This column will auto-populate.]

*Column 8 – HSN and Uninsured Care Inpatient Days*

Enter total HSN and Uninsured Care inpatient days for each routine cost center on lines 30-46 from provider records.

*Column 9 – Total HSN and Uninsured Care Inpatient Costs*

Calculate total HSN and Uninsured Care inpatient costs for each routine cost center by multiplying the days in column 8 by the per diem in column 3. [This column will auto-populate.]

Schedule C: Computation of Massachusetts Medicaid Managed Care (MMCO) and HSN and Uninsured Costs

For the purposes of completing Schedule C:

- Massachusetts Medicaid Managed Care Charges include only those charges for the following:
  - Medically necessary services as defined in 130 CMR 450.204;
  - MassHealth covered inpatient and outpatient hospital services provided to MassHealth patients eligible pursuant to Titles XIX and XXI and enrolled in a MassHealth contracting MCO, SCO, PACE, PIHP and PAHP (MMCO) at the time of service delivery.
  
- Medicaid Managed Care Charges may not include:

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

- Charges associated with services provided to MassHealth members where the service is covered under MassHealth Fee-for-Service, including the Primary Care Clinician program;
  - Charges associated with claims that have been final denied for payment by the MMCO;
  - Charges associated with state programs that are not Title XIX and Title XXI programs (e.g., the Children’s Medical Security Plan);
  - Charges reported as HSN and Uninsured Care (below).
- HSN and Uninsured Care Inpatient and Outpatient Charges are defined as those charges associated with care provided by hospitals for medically necessary services, including services reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity provided to:
    - Individuals with no health insurance coverage;
    - Low-Income Patients (under state regulation 114.6 CMR 12.03 (3) or (4) or its successor regulation) with no health insurance coverage;
    - Low-Income Patients (under state regulation 114.6 CMR 12.03 (3) or (4) or its successor regulation) whose public or private health insurance plan does not cover the cost of the particular service (excluding unpaid coinsurance and/or deductible amounts); or
    - Medicaid-eligible patients whose medical service is not paid by MassHealth or the Massachusetts Medicaid Managed Care Organizations, SCO, ICO, PACE, PIHP or PAHP;
  - HSN and Uninsured Care Charges, for the purpose of Schedule C of the UCCR, shall exclude charges associated with:
    - Professional component of physician charges;
    - Overhead charges related to physician services.

*Column 1 – Hospital Cost-to-Charge Ratios*

Enter the hospital cost-to-charge ratio for each cost center from Schedule A: MassHealth Fee-for-Service (FFS) Costs column 5. [This column will auto-populate.]

*Column 2 – Massachusetts Medicaid Managed Care Inpatient Charges*

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

Enter from hospital records inpatient charges, by cost center, related to Massachusetts Medicaid managed care patients.

*Column 3 – Massachusetts Medicaid Managed Care Inpatient Costs*

Massachusetts Medicaid managed care inpatient costs are determined by multiplying the Massachusetts Medicaid managed care inpatient charges for each cost center from column 2 by the respective hospital cost-to-charge ratios from column 1. However, for lines 30-46, costs are determined using a per diem methodology via Schedule B. [This column will auto-populate.]

*Column 4 – Massachusetts Medicaid Managed Care Outpatient Charges*

Enter from hospital records outpatient charges, by cost center, related to Massachusetts Medicaid managed care patients.

*Column 5 – Massachusetts Medicaid Managed Care Outpatient Costs*

Massachusetts Medicaid managed care outpatient costs are determined by multiplying the Massachusetts Medicaid managed care outpatient charges for each cost center from column 4 by the respective hospital cost-to-charge ratios from column 1.

*Column 6 – Total Massachusetts Medicaid managed care Inpatient and Outpatient Costs*

Total Massachusetts Medicaid managed care inpatient and outpatient costs are determined by adding the Massachusetts Medicaid managed care inpatient costs from column 3 and the Massachusetts Medicaid managed care outpatient costs from column 5.

*Column 7 – HSN and Uninsured Care Inpatient Charges*

Enter from hospital records inpatient charges, by cost center, related to HSN and Uninsured Care patients.

*Column 8 – HSN and Uninsured Care Inpatient Costs*

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

For Lines 50 through 117, HSN and Uninsured Care inpatient costs are determined by multiplying the HSN and Uninsured Care inpatient charges for each cost center from column 7 by the respective hospital cost-to-charge ratios from column 1; for lines 30-46, costs are determined using a per diem methodology via Schedule B. [This column will auto-populate through line 94.]

*Column 9 – HSN and Uninsured Care Outpatient Charges*

Enter from the hospital records outpatient charges by cost center related to HSN and Uninsured patients.

*Column 10 – HSN and Uninsured Care Outpatient Costs*

HSN and Uninsured Care outpatient costs are determined by multiplying the HSN and Uninsured Care outpatient charges for each cost center from column 9 by the respective hospital cost-to-charge ratios from column 1.

*Column 11 – Total HSN and Uninsured Care Costs*

Total uncompensated care inpatient and outpatient costs are determined by adding the HSN and Uninsured Care inpatient costs from column 8 and the HSN and Uninsured Care outpatient costs from column 10.

Schedule D: Computation of Uncompensated Care Physician Costs

For purposes of completing Schedule D:

Uncompensated Physician Costs are limited to those charges incurred by hospital-based physicians for professional services.

- MassHealth FFS Inpatient and Outpatient Charges include only those charges for the following:
  - Medically necessary services as defined in 130 CMR 450.204;
  - MassHealth covered hospital-based physician professional services provided to MassHealth patients eligible pursuant to Titles XIX and XXI at the time of service delivery.
  - Charges associated with the professional component of hospital-based physicians services.

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

- MassHealth FFS Hospital-Based Physician Professional Charges may not include:
  - Charges associated with services provided to MassHealth members where the service is covered by a Medicaid Managed Care Organization;
  - Charges associated with claims that have been final denied for payment by MassHealth;
  - Charges associated with state programs that are not Title XIX and Title XXI programs (e.g., the Children’s Medical Security Plan);
  
- Massachusetts Medicaid Managed Care Charges include only those charges for the following:
  - Medically necessary services as defined in 130 CMR 450.204;
  - MassHealth covered hospital-based physician professional services provided to MassHealth patients eligible pursuant to Titles XIX and XXI and enrolled in a MassHealth contracting MCO, SCO, PACE, PIHP and PAHP (MMCO) at the time of service delivery;
  - Charges associated with professional component of hospital-based physician services.
  
- Medicaid Managed Care Charges may not include:
  - Charges associated with services provided to MassHealth members where the service is covered under MassHealth Fee-for-Service, including the Primary Care Clinician program;
  - Charges associated with claims that have been final denied for payment by the MMCO;
  - Charges associated with state programs that are not Title XIX and Title XXI programs (e.g., the Children’s Medical Security Plan);
  - Charges reported as HSN and Uninsured Care (below).
  
- HSN and Uninsured Care Physician Charges are defined as those physician charges associated with care provided for medically necessary services, including services reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity provided to:
  - Individuals with no health insurance coverage;
  - Low-Income Patients (under state regulation 114.6 CMR 12.03 (3) or (4) or its successor regulation) with no health insurance coverage;
  - Low-Income Patients (under state regulation 114.6 CMR 12.03 (3) or (4) or its successor regulation) whose public or private health



**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

- insurance plan does not cover the cost of the particular service (excluding unpaid coinsurance and/or deductible amounts); or
- Medicaid-eligible patients whose medical service is not paid by MassHealth or the Massachusetts Medicaid Managed Care Organizations, SCO, ICO, PACE, PIHP or PAHP;

*Column 1 – Professional Component of Physicians’ Costs*

The professional component of physicians’ costs come from the hospital’s most recently filed Medicare cost report (CMS 2552) Worksheet A-8-2, column 4.

*Column 2 – Overhead Costs Related to Physicians’ Services*

If the overhead costs related to physicians’ services were adjusted out of the physicians’ costs entered on Worksheet A-8-2, enter those overhead costs from Worksheet A-8 to the corresponding cost center.

*Column 3 – Total Physicians’ Costs*

Total Physicians’ costs are determined by adding column 1 and column 2. [This column will auto-populate.]

*Column 4 – Total Physician Inpatient and Outpatient Charges*

Enter the total charges related to physician inpatient and outpatient services from hospital records to the corresponding cost center.

*Column 5 – Cost-to-Charge Ratios*

For each cost center, a cost-to-charge ratio is calculated by dividing total physicians’ costs in column 3 by total physician charges in column 4. [This column will auto-populate.]

*Column 6 – MassHealth FFS Physician Inpatient and Outpatient Charges*

Enter by cost center the total charges related to physician inpatient and outpatient services for MassHealth FFS patients from hospital records.

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

*Column 7 – MassHealth FFS Physician Inpatient and Outpatient Costs*

MassHealth FFS physician inpatient and outpatient costs are determined for each cost center by multiplying the MassHealth FFS inpatient and outpatient physician charges from column 6 by the cost-to-charge ratio from column 5. [This column will auto-populate.]

*Column 8 – Massachusetts Medicaid Managed Care Physician Inpatient and Outpatient Charges*

Enter the total charges related to physician inpatient and outpatient services for Massachusetts Medicaid managed care patients from hospital records.

*Column 9 – Massachusetts Medicaid Managed Care Physician Inpatient and Outpatient Costs*

Massachusetts Medicaid managed care physician inpatient and outpatient costs are determined for each cost center by multiplying the Massachusetts Medicaid managed care inpatient and outpatient physician charges from column 8 by the cost-to-charge ratio from column 5. [This column will auto-populate.]

*Column 10 – HSN and Uninsured Care Physician Inpatient and Outpatient Charges*

From provider records, enter the charges related to physician inpatient and outpatient services for HSN and Uninsured Care patients as defined above.

*Column 11 – HSN and Uninsured Care Physician Inpatient and Outpatient Costs*

HSN and Uninsured Care physician inpatient and outpatient costs are determined for each cost center by multiplying the HSN and Uninsured Care inpatient and outpatient physician charges from column 10 by the cost-to-charge ratio from column 5. [This column will auto-populate.]

*Column 12 – Total Massachusetts Medicaid Fee-For-Service, Medicaid Managed Care and HSN and Uninsured Care Inpatient and Outpatient Physician Costs*

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

Total Massachusetts Medicaid Fee-For-Service, managed care and HSN and Uninsured Care inpatient and outpatient physician costs are determined by adding column 9 and column 11.

Schedule E: Safety Net Health Care System (SNCHS) Expenditures

Pursuant to Section 49 (c) of the 1115 demonstration Special Terms and Conditions, expenditures for payments to providers is authorized under the safety net care pool to support uncompensated care for “Medicaid FFS, Medicaid managed care, and low-income uninsured individuals.” This Schedule E provides health care providers the opportunity to itemize such system expenditures for the Medicaid-eligible and uninsured population and includes the additional allowable costs outlined in the Development Tool approved by CMS on September 6, 2013 and any additional allowable costs described in the Cost Element table of this document. .

*Column 1 – Total System Expenditures*

Enter total safety net health care system expenditures for each line item.

*Column 2 – Medicaid-eligible / HSN and Uninsured Payer Mix Proportion*

To determine the proportion of total system expenditures attributable to Medicaid-eligible and uninsured patients, first estimate the total charges for the year attributable to this group; next, estimate the total charges for the year attributable to all patients served by the SNHCS. The ratio of these two numbers will be used to estimate the amount of system expenditures attributable to Medicaid-eligible and uninsured patients. Enter this ratio in column 2. Should an alternative ratio be more appropriate, enter that number, and then explain the basis for it in the Narrative Description section of Schedule E.

*Column 3 – Medicaid-eligible / HSN and Uninsured Share of System Expenditures*

Calculate the system expenditures attributable to Medicaid-eligible and uninsured patients by multiplying the total system expenditure in column 1 by the payer mix proportion in column 2. [This column will auto-populate.]

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

Schedule F: Medicaid and Uninsured Revenue

Note: Hospitals must ensure that any applicable revenues pertaining to Medicaid or uninsured costs allowed in Schedule E are captured in Schedule F and are treated as an offset to arrive at net uncompensated care costs.

Line Instructions:

Hospital and Clinic Revenue:

In lines 1-8, enter amounts paid for services provided by the hospital and any provider-based satellites, including hospital-licensed health centers.

Line 1 – Payer Medical Claims Revenue

For each column, enter in line 1 the total amount paid by the payer for medical claims. Do not include payments for that are not related to claims, such as pay-for-performance payments or supplemental payments. The amounts reported must reflect any post-payment reconciliations or recoupments, subject to the availability of that data.

Column 5 - Health Safety Net and Uninsured

In line 1, column 5, report the gross payments received from the HSN and Uninsured. Do not offset the amount of the HSN Assessment.

Line 2 – Pay-for-Performance / Incentive Payment Revenue

This revenue data is reported for informational purposes only. Payments that are not service payments for the provision of medical care are not offset against the eligible cost. Since the following payments are not payments for the provision of medical care, they are not offset against the eligible cost: SNCP grants and performance-based, incentive, and shared savings payments. These include performance-based and incentive-based payments and grants and awards both currently in existence and those that may be approved and implemented during future demonstration renewal periods.

Enter in line 2 any amounts paid by the payer for pay-for-performance or other incentive payments. The amount reported must also include any recoveries made by the payer for performance issue, such as retrospective performance penalties.

Line 3-5 – Supplemental Payments

Enter in lines 3-5 any amounts paid by the payer for supplemental payments. Specify the type of supplemental payment reported by modifying the title of the line. The total

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

gross payment must be reported; do not offset any payment amount by any intergovernmental transfer amounts that may have been made by a related public entity.

**Line 6 – Medicare Revenue**

Enter in line 6 any payments amounts received by Medicare for services provided to patients who are eligible for both Medicare and the payer noted in the column.

**Line 7 – Third Party and Self Pay Revenue**

Enter in line 7 any payment amounts received by third parties, the patient, or the patient's guarantor for the cost-sharing or services not covered by the payer noted in the column.

**Line 8 – Other Revenue**

Enter in line 8 any additional revenue from the payer for the Medicaid-eligible and uninsured populations not included in lines 1-7. Specify the type of revenue by modifying the title of the line. Additional information may be provided in the Notes tab.

**Line 9 – Subtotal Hospital and Clinic**

Sum of lines 1-8. [This line will auto-populate.]

**Lines 10-15 Physician Revenue**

Using the same descriptions in the corresponding lines 1-8, report physician revenue related to the payers.

**Line 16 – Subtotal Physician Revenue**

Sum of lines 10-15. [This line will auto-populate.]

**Line 17 – Total Revenue.**

Sum of lines 9 and 16. [This line will auto-populate.]

**Column Instructions.**

***Column 1 – Medicaid FFS Inpatient Revenue***

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

Report in column 1, amounts paid by MassHealth for inpatient services provided to members enrolled in the MassHealth program, excluding those enrolled in MassHealth managed care programs.

*Column 2 – Medicaid FFS Outpatient Revenue*

Report in column 2, amounts paid by MassHealth for outpatient services provided to members enrolled in the MassHealth program, excluding those enrolled in MassHealth managed care programs.

*Column 3 – Medicaid Managed Care Inpatient Revenue*

Report in column 3, amounts paid by Medicaid Managed Care Organizations for inpatient services provided to members.

*Column 4 – Medicaid Managed Care Outpatient Revenue*

Report in column 4, amounts paid by Medicaid Managed Care Organizations for outpatient services provided to members.

*Column 5 – HSN and Uninsured Inpatient and Outpatient Revenue*

Report in column 5, amounts paid by the HSN and Uninsured individuals for inpatient and outpatient services provided. Report the gross payments received from the HSN. Do not offset the amount of the HSN Assessment.

*Column 6 – Total Revenue*

Sum of columns 1 through 5. [This column will auto-populate.]

Schedule G: Notes

Providers may use Schedule G to provide additional information on the data reported.

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

**III. Uniform Financial Report (UFR)**

CBDCs are entities that provide health care services for substance abuse that contract with the MassHealth agency, Medicaid Managed Care Entities and the Bureau of Substance Abuse Services, the latter providing services to the uninsured. Each CBDC is licensed by the Bureau of Substance Abuse Services under the requirements set forth in 105 CMR 164.000. Because CBDCs are not a hospital, they do not fill out the Medicare CMS-2552 cost report and instead fill out the Uniform Financial Report (UFR).

UFR reports are filed with the Massachusetts Operational Services Division (OSD) on an annual basis. This report captures administration and support costs, as defined in 808 CMR 1.00, which includes expenditures for the overall direction of the organization, e.g., general record keeping, budgeting, etc., but also the salaries and expenses of the organization's staff. The report will also capture expenditures for health care services, as defined in M.G.L. c. 118 § 2 (b), the pricing of which is set by the Center for Health Information and Analysis

The CBDCs are required to keep necessary data on file to satisfy the UFR reporting requirements, and books and records must be maintained in accordance with generally accepted accounting principles set forth by the American Institute of Certified Public Accountants (AICPA).

The UFR must be submitted on or before the 15<sup>th</sup> day of the fifth month after the end of the contractor's fiscal year.

The UFR reports the following data elements:

1. Net Assets
2. Total Current Assets
3. Total Assets
4. Total Current Liabilities
5. Total Liabilities
6. Total Liabilities and Net Assets
7. Total Revenue, Gains, and Other Support
8. Total Expenses and Losses
9. Indirect / Direct Method
10. Cash from Operating Activities
11. Cash from Investing Activities
12. Cash from Financing Activities
13. Total Expenses – Programs
14. Total Expenses – Supporting Services
15. Surplus Percentage
16. Surplus Retention Liability

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

The UFR allows for revenue to be reported from Medicaid Direct Payments, Medicaid Massachusetts behavioral Health Partnership (MBHP) Subcontracts, Department of Mental Health, Department of Public Health, and other human and social service agencies.

The CBDC's program expense is broken down by provider type for Psychiatric Day Treatment and Substance Abuse Class Rate Services, including:

1. Psychiatrist
2. N.P., Psych N., N.A., R.N.-Masters
3. R.N.-Non Masters
4. L.P.N.
5. Occupational Therapist
6. Psychologist – Doctorate
7. Clinician (formerly Psych. Masters)
8. Social Worker – L.I.C.S.W.
9. Social Worker – L.C.S.W., L.S.W.
10. Licensed Counselor
11. Cert. Voc. Rehab. Counselor
12. Counselor
13. Case Worker/Manager – Masters
14. Case Worker/Manager
15. Direct Care/Program Staff Supervisor
16. Direct Care/Program Staff

**Per unit cost from UFR.** The provider will calculate a per unit cost from the UFR for inpatient detoxification programs, who do not submit the Medicare 2552 cost report, by dividing the total reimbursable program expense (Schedule B line 53E) by line 6SS (number of service units delivered). The per diem cost will be reported by the CBDC on the CBDC Protocol Form.

**Allowable Costs**

- i. From the MMIS paid claims database, the State will obtain the number of units of care, including administrative units, provided to all Medicaid patients.
- ii. Providers will be required to file a supplemental schedule with EOHHS that reports the number of units, days of care, including administrative days, for services provided to Medicaid MCO and other uninsured patients.<sup>7</sup>
- iii. The state will calculate costs by multiplying the per unit cost with the number of MassHealth, Medicaid MCO, and uninsured units described above.

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<sup>7</sup> This is not currently available on the UFR report.



**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

**Payments**

- i. From the MMIS paid claims database, the state will obtain payments made to programs for services, including administrative days, provided to MassHealth patients.
- ii. Providers will be required to file a supplemental schedule with EOHHS reporting payments received from all sources for services provided to Medicaid MCO and uninsured patients.

**Determination of Provider-Specific SNCP Limit for CBDCs**

The State will calculate a provider-specific SNCP limit for each CBDC as by subtracting all applicable payments from the allowable costs

**IV. Reconciliation**

Interim Reconciliation for CMS 2552 and UCCR Methods

Each provider's uncompensated care costs must be computed based on the provider's as-filed CMS 2552<sup>8</sup> cost report and Uniform Medicaid & Uncompensated Care Cost & Charge Report (UCCR) and for the actual service period. The CMS 2552 cost report is filed with the Medicare contractor five months after the close of the cost reporting period. The UCCR must be filed three after months after the CMS 2552 is filed. For SNCP payments subject to the cost limit pursuant to STC 49(c), each provider's allowable Medicaid, uncompensated care, and uninsured costs must be reconciled against associated applicable payments received for the year for which the payments were made.

For hospitals whose accounting fiscal year aligns with the cost limit reporting fiscal year (Federal fiscal year), the Medicaid and uninsured costs will be reflected in the CMS 2552 and UCCR that is submitted for the accounting fiscal year. For acute hospitals whose accounting fiscal years do not align with the reporting fiscal year, the reporting year cost limit will be calculated by applying the appropriate percentage of the two contiguous CMS 2552 and UCCR cost reports that span the reporting fiscal year so that the Federal fiscal year will be represented in the cost limit calculation.

The Commonwealth must recover provider overpayments as it determines necessary based on its reconciliation calculations and availability of federal financial participation.

If an overpayment exists, the Commonwealth must determine if the overpayment occurred due to Health Safety Net (HSN) Trust Fund payments or other SNCP payments, or from both payments. To the extent that the overpayment is a result of

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<sup>8</sup> Community Based Detoxification Centers are the only provider type subject to the cost limit that does not submit the CMS 2552 cost report.

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

overpaid funds from the HSN Trust Fund, the Commonwealth must recover from the provider the amount overpaid to the provider from the HSN Trust Fund and credit that amount to the HSN Trust Fund. The HSN Trust Fund will redistribute such amounts to other providers as appropriate. To the extent that the overpayment is not the result of HSN Trust Fund payments, the Commonwealth must recover from the provider the overpayment, and the Commonwealth must properly credit the federal share to the federal government.

The interim reconciliation described above must be performed and completed within twelve months after the filing of the UCCR(s).

Final Reconciliation for CMS 2552 and UCCR Methods

Each provider's uncompensated care costs must be recomputed based on the provider's audited CMS 2552 cost report for the actual service period. These recomputed costs must be carried over to the UCCR. The CMS 2552 cost report is audited and settled by the Medicare contractor to determine final allowable costs and reimbursement amounts as recognized by Medicare. For SNCP payments subject to the cost limit pursuant to STC 49(c), each provider's allowable Medicaid, uncompensated care, and uninsured costs must be reconciled against associated applicable payments received for the year for which the payments were made. SNCP uncompensated care payments made to the provider for a cost limit reporting year cannot exceed the recomputed uncompensated care cost limit. If, at the end of the final reconciliation process, it is determined that expenditures claimed exceeded the individual provider's uncompensated care cost limit, thereby causing an overpayment, the Commonwealth must recoup the overpayment from the provider. Specifically, if an overpayment exists, the Commonwealth must determine if the overpayment occurred due to HSN Trust Fund payments or other SNCP payments, or from both payments. To the extent that the overpayment is a result of overpaid funds from the HSN Trust Fund, the Commonwealth must recover from the provider the amount overpaid to the provider from the HSN Trust Fund and credit that amount to the HSN Trust Fund. The HSN Trust Fund will redistribute such amounts to other providers as appropriate. To the extent that the overpayment is not the result of HSN Trust Fund payments, the Commonwealth must recover from the provider the overpayment, and the Commonwealth must properly credit the federal share to the federal government.

For hospitals whose accounting fiscal year aligns with the cost limit reporting fiscal year (Federal fiscal year), the Medicaid and uninsured costs will be reflected in the CMS 2552 and UCCR that is submitted for the accounting fiscal year. For acute hospitals whose accounting fiscal years do not align with the reporting fiscal year, the reporting year cost limit will be calculated by applying the appropriate percentage of the two contiguous CMS 2552 and UCCR cost reports that span the reporting fiscal year so that the Federal fiscal year will be represented in the cost limit calculation.

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

The Commonwealth must recover provider overpayments as it determines necessary based on its reconciliation calculations and availability of federal financial participation.

The final reconciliation described above must be performed and completed within twelve months after all final, audited CMS 2552 cost reports become available online.

Interim Reconciliation for UFR Method

Each provider's uncompensated care costs must be computed based on the provider's as-filed Uniform Financial Report (UFR) and for the actual service period. The UFR is filed five months after the close of the cost reporting period. SNCP uncompensated care payments made to the provider for a cost limit reporting year cannot exceed the recomputed uncompensated care cost limit. Per unit cost will be derived from the as-filed UFR; and Medicaid and uninsured units of service and payments will be derived from the latest available auditable data for the service period. If, at the end of the interim reconciliation process, it is determined that expenditures claimed exceeded the individual provider's uncompensated care cost limit, the overpayment will be recouped from the provider, and the federal share will be properly credited to the federal government.

A provider's uncompensated care cost limit is determined for the twelve month period in each cost limit reporting year. For providers whose accounting fiscal year aligns with the cost limit reporting fiscal year (Federal fiscal year), the Medicaid and uninsured costs will be reflected in UFR and supplemental schedule that is submitted for the accounting fiscal year. For providers whose accounting fiscal years do not align with the reporting fiscal year, the reporting year cost limit will be calculated by applying the appropriate percentage of the two contiguous UFR and supplemental schedule reports that span the reporting fiscal year so that the Federal fiscal year will be represented in the cost limit calculation.

The interim reconciliation described above will be performed and completed within twelve months after the filing of the provider's UFR.

Final Reconciliation for the UFR Method

Each provider's uncompensated care costs must be recomputed based on the provider's audited UFR for the actual service period. The UFR is audited and settled by the Commonwealth to determine final allowable costs and reimbursement amounts as recognized by the Commonwealth based on this cost limit protocol. SNCP uncompensated care payments made to the provider for a cost limit reporting year cannot exceed the recomputed uncompensated care cost limit. Per unit cost will be derived from the as-filed UFR; and Medicaid and uninsured units of service and payments will be derived from the latest available auditable data for the service

**Massachusetts MassHealth Section 1115 Demonstration Safety Net Care Pool  
Uncompensated Care Cost Limit Protocol  
December 11, 2013**

period. If, at the end of the final reconciliation process, it is determined that expenditures claimed exceeded the individual provider's uncompensated care cost limit, the overpayment will be recouped from the provider, and the federal share will be properly credited to the federal government. Settlement of any over- or underpayment to a provider will be treated as a separate transaction rather an adjustment to the following year's interim payment.

A provider's uncompensated care cost limit is determined for the twelve month period in each cost limit reporting year. For providers whose accounting fiscal year aligns with the cost limit reporting fiscal year (Federal fiscal year), the Medicaid and uninsured costs will be reflected in UFR and supplemental schedule that is submitted for the accounting fiscal year. For providers whose accounting fiscal years do not align with the reporting fiscal year, the reporting year cost limit will be calculated by applying the appropriate percentage of the two contiguous UFR and supplemental schedule reports that span the reporting fiscal year so that the Federal fiscal year will be represented in the cost limit calculation.

The final reconciliation described above will be performed and completed within twelve months after the audited provider UFR is made available.