DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S3-13-15
Baltimore, Maryland 21244-1850

Center for Medicaid, CHIP, and Survey and Certification

Ms. Carol A. Herrmann-Steckel, MPH
Commissioner
Alabama Medicaid Agency
501 Dexter Avenue
P.O. Box 5624
Montgomery, Alabama 36103-5624

SEP - 1 2010

Attention: Robert Church

RE: TN 05-009

Dear Ms. Steckel:

We have reviewed the proposed amendment to Attachments 3.1-A and 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 05-009. Effective October 1, 2005, this amendment proposes to revise the State's reimbursement methodology to pay disproportionate share hospital (DSH) payments to public providers using certified public expenditures (CPE) as the non-federal share funding source of the payments. In addition, this amendment proposes to expand the coverage definition of outpatient hospital services within the State of Alabama.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(13), 1902(a)(30), 1903(a) and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR Part 447. As part of our review we noted items in the State's calculation of hospital specific DSH limits that would need to be addressed as part of the transition period permitted by the DSH final audit and reporting rule published in the Federal Register on December 19, 2008 (77904 – 77952). Specifically, we noted:

- the State included uncovered Medicaid days in excess of the State's 16 day inpatient hospital coverage limit as uncompensated care for DSH purposes;
- the State employed a hospital specific cost to charge ratio to determine ancillary costs in the calculation of its DSH CPE; and
- and the State offset recoveries from individuals with no source of third party insurance against charges related to individuals with no source of third party insurance prior to applying charges against cost per diems and cost to charge ratios.

These items, as well as other findings from the State's independent DSH audits will need to be addressed in accordance with the final DSH rule.

The proposed changes in payment methodology comply with applicable requirements and therefore have approved them with an effective date of October 1, 2005. We are enclosing the CMS-179 and the amended approved plan pages.

If you have any questions, please call Stanley Fields at (502) 223-5332 or Venesa Day at 410-786-8281.

Sincerely,

//s//

Cindy Mann
Director, CMCS

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL	1. TRANSMITTAL NUMBER: 05-09	2. STATE Alabama
FOR: HEALTH CARE FINANCING ADMINISTRATION	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE 10/1/05	

5. TYPE OF PLAN MATERIAL *(Check One)*:
☐ NEW STATE PLAN ☒ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☐ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:	7. FEDERAL BUDGET IMPACT:
42 CFR 430 Subpart B	a. FFY 06 $ 0 b. FFY 07 $ 0
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A, page 20 & 21	N/A

10. SUBJECT OF AMENDMENT:

Certified Public Expenditures for inpatient and outpatient hospitals.

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: Governor's designee on file via letter with CMS

12. SIGNATURE OF STATE AGENCY OFFICIAL: //s//	16. RETURN TO: Carol A. Herrmann-Steckel Commissioner Alabama Medicaid Agency 501 Dexter Avenue P.O. Box 5624 Montgomery, Alabama 36103-5624
13. TYPED NAME: Carol Herrmann-Steckel	
14. TITLE: Commissioner	
15. DATE SUBMITTED:12-30-05	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 12-30-05	18. DATE APPROVED: 09-01-10
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: 10-01-05	20. SIGNATURE OF REGIONAL OFFICIAL: //s//
21. TYPED NAME: Cindy Mann	22. TITLE: Director, CMCS

23. REMARKS:

Approved with the following changes to item, 8 and 9 as authorized by State Agency e-mail dated 08/26/10

Block # 8 changed to read: Attachment 3.1-A page 1.2 and 4.19-A pages 20 thru 20.31.

Block# 9 changed to read: Attachment 3.1-A page 1.2.

Limitation of Services

2.a. **Outpatient Hospital Services**

Additional medically necessary services beyond limitations are covered for children under 21 years of age that are eligible for E.P.S.D.T. services.

Effective Date: 01/01/94
Non-certified emergency room visits will be restricted to three (3) per calendar year unless prior authorized. Certified emergency room visits must be properly documented by the attending physician in the medical record.

Limitation of Services

2.d. **Outpatient Hospital Services**

Outpatient hospital services will include the following provider based entities, in accordance with 42 CFR 413.65:

1) Hospital Based Physician services,
2) Hospital Based Ambulance Services,
3) Hospital Based Home Health Services,
4) Hospital Based Hospice,
5) Hospital Based Pharmacy Prescription Services,
6) Hospital Based Durable Medical Equipment,
7) Hospital Based Outpatient Renal Dialysis Services, and
8) Hospital Based Rural Health Center/Federally Qualified Health Center

EXHIBIT C
Page 1

Disproportionate Share Hospitals - Certified Public Expenditures for uncompensated costs incurred in providing services to Medicaid and individuals with no source of third party insurance.

The Alabama Medicaid Agency uses the **CMS Form 2552-96** cost report for its Medicaid program and all acute care hospitals must submit this report each year. The Agency will determine the uncompensated costs of Medicaid services and services to individuals with no source of third party insurance to be certified as public expenditures (CPE) from the **CMS Form 2552-96** for both inpatient and outpatient services provided by hospitals. The Agency will use the protocol below.

Cost of Medicaid

1. Interim Reconciliation of Interim Medicaid Inpatient Hospital Payment Rate Post Reporting Year: Upon completion of the State fiscal year, each hospital's interim payments will be reconciled to its CMS Form 2552-96 cost report as filed to the fiscal intermediary (FI) for purposes of Medicare reimbursement for the respective cost reporting period. For hospitals that have a cost reporting period that differs from the State fiscal year end date of September 30th, the cost reports that overlap the State fiscal year will be used for the calculation. The reconciliation will occur upon receipt of the electronic CMS Form 2552-96 cost report that includes the September 30th fiscal year end of the State.

   Prior to calculation of cost to charge ratios for interim reconciliation, the Worksheet A-6 reclassification and Worksheet A-8 adjustment related to certified registered nurse anesthetists (CRNA) will be reversed on each hospital's CMS Form 2552-96 cost report. In addition, the inpatient and outpatient charges related to CRNAs will have to be obtain from each hospital's financial records and included on Worksheet C for a proper calculation of cost to charge ratios including CRNA for inpatient services due to the State not reimbursing separately for hospital employed CRNAs for inpatient services.

   The State will apply the cost per diems calculated on the Medicaid Worksheet D-1 Part II lines 38 and 42-47 to routine days from Worksheet S-3 lines 5-11 and 14 to determine Medicaid routine service cost and cost to charge ratios calculated on the Medicaid Worksheet D-4 to inpatient ancillary charges related to CMS Lines 37-63 to determine Medicaid inpatient ancillary service cost. Medicaid cost per diems and cost to charges ratios shall include the cost of graduate medical education on Worksheet B Part I columns 22 and 23.

   Medicaid inpatient charges include Fee For Service and Prepaid Health Plan (PHP) billed amounts, denied billed amounts (amount that would have been paid if PHPs had not run out of funds) and inpatient maternity waiver charges (derived from individual hospital surveys).

In addition to the cost calculated through application of cost per diems to routine service charges and cost to charge ratios to ancillary charges, a calculation of organ acquisition cost will be made for transplant approved hospitals eligible to certify public expenditures. The Worksheet D-6 series with the above modifications for each organ will be used to determine organ acquisition cost. The total amount of Medicaid organ acquisition cost will be calculated as follows: Total organ acquisition cost per Worksheet D-6 Part III Line 53 divided by Total usable organs per Worksheet D-6 Part III Line 54 times number of Medicaid organs (both fee for service and managed care) transplanted during the year.

Total Medicaid inpatient cost therefore will be the sum of routine service cost, ancillary service cost and organ acquisition cost. Third party and client responsibility payments are deducted from the total Medicaid inpatient cost to determine the certifiable amount. The State will compare the interim reconciliation to the Medicaid expenditures for each hospital. Any difference to the reimbursement amount will be recorded as an adjustment on the CMS 64 report.

2. Final Reconciliation of Interim Medicaid Inpatient Hospital Payment Rate Post Reporting Year: Upon issuance of a Notice of Program Reimbursement for CMS Form 2552-96 cost report(s) that incorporate the State fiscal year, each hospital's interim reconciliation will be reconciled to its CMS Form 2552-96 cost report as adjusted by the fiscal intermediary (FI) for purposes of Medicare reimbursement for the respective cost reporting period(s). For hospitals that have a cost reporting period that differs from the State fiscal year end date of September 30th, the cost reports that overlap the State fiscal year will be used for the calculation.

   Prior to calculation of cost to charge ratios for interim reconciliation, the Worksheet A-6 reclassification and Worksheet A-8 adjustment related to certified registered nurse anesthetists (CRNA) will be reversed on each hospital's CMS Form 2552-96 cost report. In addition, the inpatient and outpatient charges related to CRNAs will have to be obtain from each hospital's financial records and included on Worksheet C for a proper calculation of cost to charge ratios including CRNA for inpatient services due to the State not reimbursing separately for hospital employed CRNAs for inpatient services.

   The State will apply the cost per diems calculated on the Medicaid Worksheet D-1 Part II lines 38 and 42-47 to routine days from Worksheet S-3 lines 5-11 and 14 to determine Medicaid routine service cost and cost to charge ratios calculated on the Medicaid Worksheet D-4 to inpatient ancillary charges related to CMS Lines 37-63 to determine Medicaid inpatient ancillary service cost. Medicaid cost per diems and cost to charges ratios shall include the cost of graduate medical education on Worksheet B Part I columns 22 and 23.

Medicaid inpatient charges include Fee For Service and Prepaid Health Plan (PHP) billed amounts, and denied billed amounts (amount that would have been paid if PHPs had not run out of funds).

In addition to the cost calculated through application of cost per diems to routine service charges and cost to charge ratios to ancillary charges, a calculation of organ acquisition cost will be made for transplant approved hospitals eligible to certify public expenditures. The Worksheet D-6 series with the above modifications for each organ will be used to determine organ acquisition cost. The total amount of Medicaid organ acquisition cost will be calculated as follows: Total organ acquisition cost per Worksheet D-6 Part III Line 53 divided by Total usable organs per Worksheet D-6 Part III Line 54 times number of Medicaid organs (both fee for service and managed care) transplanted during the year.

Total Medicaid inpatient cost therefore will be the sum of routine service cost, ancillary service cost and organ acquisition cost. Third party and client responsibility payments are deducted from the total Medicaid inpatient cost to determine the certifiable amount. The State will compare the final reconciliation to the interim reconciliation for each hospital. Any difference to the reimbursement amount will be recorded as an adjustment on the CMS 64 report.

Cost of the uninsured

3. Calculation of Interim Disproportionate Share Hospital (DSH) Limit: A base year will be used to calculate the uncompensated care cost of the uninsured and Medicaid eligible beneficiaries. The base year will be the State fiscal year beginning two years prior to the reporting year (ex. 2004 data for 2006 payments). Due to Medicaid services within the State for hospitals eligible to certify public expenditures being certified at cost, there will be no uncompensated care for these services. Therefore, the Interim DSH Limit for each hospital will be the estimated compensated care for inpatient and outpatient services to individuals with no source of third party insurance plus the uncompensated care (including potential surplus) for inpatient and outpatient services, as well as outpatient other services, to Medicaid eligible individuals

   This computation of establishing interim DSH payment funded by CPEs must be performed on an annual basis and in a manner consistent with the instructions below.

   a. Using the CMS Form 2552-96 cost report for the fiscal year ending during the fiscal year data being used (ex. 2004 data for 2006 payments), a cost to charge ratio will be determined at the facility level. The data sets used to calculate the cost to charge ratio are Worksheet C, Part I, column 5, line 103 less lines 32 and 34-36 (total cost), column 6, line 103 less lines 32

and 34-36 (inpatient charges), column 7, line 103 less lines 32 and 34-36 (outpatient charges) and column 8, line 103 less lines 32 and 34-36 (total charges). The cost-to-charge ratio (CCR) was determined by dividing total costs by total charges, with the same CCR ratio used for inpatient and outpatient.

b. The inpatient and outpatient Medicaid charges will be multiplied by the CCR to determine Medicaid cost. Payments made related to these Medicaid charges would be used to offset the Medicaid cost to determine uncompensated Medicaid cost.

c. The inpatient and outpatient charges related to individuals with no source of third party coverage will be multiplied by the CCR to determine the cost of services to individuals with no source of third party insurance. Payments related to these individuals will be used to offset the cost of services to determine the uncompensated cost of services to individuals with no source of third party insurance.

d. The uncompensated care of services for individuals with no source of third party insurance will be combined with the uncompensated Medicaid cost to determine the uncompensated care cost. Any Medicaid payments in excess of Medicaid cost will be used to offset uncompensated care of services for individuals with no source of third party insurance.

e. The uncompensated care cost calculated will be trended by the hospital market basket index as published by Global Insight Health-Care Cost Review to determine the interim DSH limit for the reporting year payments being calculated.

4. Interim Reconciliation of Interim Disproportionate Share Hospital (DSH) Limit Post Reporting Year: Upon completion of the State's reporting year, each hospital's interim payments will be reconciled to its CMS Form 2552-96 cost report as filed to the fiscal intermediary (FI) for purposes of Medicare reimbursement for the respective cost reporting period. For hospitals that have a cost reporting period that differs from the State fiscal year end date of September 30th, the cost reports that overlap the State fiscal year will be used for the calculation. The reconciliation will occur upon receipt of the electronic CMS Form 2552-96 cost report that includes the September 30th fiscal year end of the State.

   Prior to calculation of cost to charge ratios and cost per diems for interim reconciliation for Medicaid eligible individuals, the Worksheet A-6 reclassification and Worksheet A-8 adjustment related to certified registered nurse

anesthetists (CRNA) will be reversed on each hospital's CMS Form 2552-96 cost report. In addition, the inpatient and outpatient charges related to CRNAs will have to be obtain from each hospital's financial records and included on Worksheet C for a proper calculation of cost to charge ratios including CRNA for inpatient services due to the State not reimbursing separately for hospital employed CRNAs for inpatient services.

Prior to calculation of cost to charge ratios and cost per diems for interim reconciliation for individuals with no source of third party insurance, the following items will be completed in adapting the cost report.

a. The Worksheet A-6 reclassification and Worksheet A-8 adjustment related to certified registered nurse anesthetists (CRNA) will be reversed on each hospital's CMS 2552 cost report. In addition, the inpatient and outpatient charges related to CRNAs will have to be obtain from each hospital's financial records and included on Worksheet C for a proper calculation of cost to charge ratios including CRNA for inpatient services due to the State not reimbursing separately for hospital employed CRNAs for inpatient services.

b. The Worksheet A-8-1 adjustments will be reversed to allow cost to be reported at cost to the related party.

c. All non-professional services related adjustments on Worksheet A-8 will be removed from the cost report to allow cost to be reported with only adjustments related to professional services (excluding CRNA) will be used to offset cost.

The State will use MMIS for Fee For Service inpatient routine, inpatient ancillary, outpatient ancillary and outpatient other services days and charge information for each hospital. Also, each hospital will supply the State with detailed charge information for services provided to Medicaid eligible individuals not considered Fee For Service activity by the State for inpatient services, outpatient services, and outpatient other services. (ex. Out of State Medicaid, Managed Care). Each hospital will supply detailed charge days and charges information for services provided to individuals with no source of third party insurance for inpatient services, outpatient services, and other outpatient services.

The State will apply the cost per diems calculated on the Medicaid Worksheet D-1 Part II lines 38 and 42-47 to routine days that would be reported on Worksheet S-3 lines 5-11 and 14 to determine routine service cost and cost to charge ratios calculated on the Medicaid Worksheet D-4 to inpatient ancillary charges related to CMS Lines 37-63 to determine inpatient ancillary service cost and cost to

charge ratios calculated on the Medicaid Worksheet D Part V to outpatient ancillary charges related to CMS Lines 37-63 to determine outpatient ancillary service cost. CMS Form 2552-96 cost reporting schedules for outpatient other services will be used for calculation of cost as stated in paragraph e under the calculation of uncompensated cost of care for services provided to Medicaid eligible individuals and paragraph f under the calculation of uncompensated cost of care for services provided to individuals with no source of third party insurance. Medicaid cost per diems and cost to charges ratios, as well as outpatient other services cost calculations, shall include the cost of graduate medical education on Worksheet B Part I columns 22 and 23.

In addition to the cost calculated through application of cost per diems to routine service charges and cost to charge ratios to ancillary charges, a calculation of organ acquisition cost will be made for transplant approved hospitals eligible to certify public expenditures. The Worksheet D-6 series with the above modifications for each organ will be used to determine organ acquisition cost. The total amount of organ acquisition cost will be calculated as follows: Total organ acquisition cost per Worksheet D-6 Part III Line 53 divided by Total usable organs per Worksheet D-6 Part III Line 54 times number of organs transplanted during the year.

Uncompensated cost of care for services provided to Medicaid eligible individuals shall be calculated as follows:

a. Applying the inpatient routine Medicaid charges from provider records to the applicable cost per diem per the Medicaid Worksheet D-1 to determine Medicaid routine cost.

b. Applying the inpatient ancillary Medicaid charges from provider records to the applicable cost to charge ratio per the Medicaid Worksheet D-4 to determine Medicaid inpatient ancillary cost.

c. Applying the outpatient ancillary Medicaid charges from provider records to the applicable cost to charge ratio per the Medicaid Worksheet D Part V to determine Medicaid outpatient ancillary cost.

d. Determining the cost of Medicaid organ acquisition cost for any Medicaid transplants identified.

e. Determine the cost of Medicaid outpatient other services as follows:

1. Physician Services

a. The professional component of physician costs are identified from each hospital's most recently filed CMS Form 2552-96 or future version of cost report Worksheet A-8-2, Column 4.

These professional costs meeting the following requirements:

i. Limited to allowable and auditable physician compensations that have been incurred by the hospital;

ii. For the professional, direct patient care furnished by the hospital's physicians in all applicable sites of service.

iii. Identified as professional costs on Worksheet A-8-2, Column 4 of the cost report of the hospital claiming payment

iv. supported by a time study, accepted by Medicare for Worksheet A-8-2 reporting purposes, that identified the professional, direct patient care activities of the physicians (not applicable to registry physicians discussed above)

v. Removed from hospital costs on Worksheet A-8.

b. The professional costs on Worksheet A-8-2, Column 4 are subject to further adjustments and offsets, including any necessary adjustment to bring the costs in line with Medicare cost principles. However, Medicare physician reasonable compensation equivalents are not applied for Medicaid physician professional cost determination purposes. There will be revenue offsets to account for revenues received for services by such professionals to non-patients (patients whom the hospital does not directly bill for) and any other applicable non-patient care revenues that were not previously offset or accounted for by the application of time study.

c. Reimbursement for other professional practitioner service costs that have also been identified and removed from hospital costs on the CMS Form 2552-96 or future version of cost report. The practitioner types to be included are:

i. Nurse Practitioners
ii. Physician Assistants
iii. Dentists
iv. Certified Nurse Midwives
v. Clinical Social Workers

vi. Clinical Psychologists
vii. Optometrists

d. To the extent these practitioners' professional compensation costs are not included in Worksheet A-8-2, Column 4, but are removed from hospital costs through an A-8 adjustment on the CMS Form 2552-96 or future version of cost report, these costs may be recognized if they meet the following criteria:

   i. the practitioners must engage in the direct provision of care in addition to being Medicaid-qualified practitioners for whom the services are billable under Medicaid separate from hospital services;
   ii. for all non physician practitioners there must be an identifiable and auditable data source by practitioner type;
   iii. a CMS-approved time study must be employed to allocate practitioner compensation between clinical and non-clinical costs as required under CMS Publication 15-II for completion of Worksheet A-8-2;
   iv. the clinical costs resulting from the CMS-approved time study are subject to further adjustments and offsets, including adjustments to bring the costs in line with Medicare cost principles and offset of revenues received for services by such practitioners to non-patients (patients for whom the hospital does not directly bill for) and other applicable non-patient care revenues that were not previously offset or accounted for by the application of CMS-approved time study.

   The resulting net clinical non-physician practitioner compensation costs are allowable costs for this Exhibit of Attachment 4.19-B. The compensation costs for each non-physician practitioner type are identified separately.

e. Professional costs incurred for freestanding clinics (clinics that are not recognized as hospital outpatient departments on the CMS Form 2552-96 or future version of) are separately reimbursable as clinic costs and therefore should not be included in this protocol.

f. Hospitals may additionally include physician support staff compensation, data processing, and patient accounting costs as physician-related costs to the extent that these costs are removed from hospital inpatient and outpatient costs because

   i. they have been specifically identified as costs related to

physician professional services;
ii. they are directly identified on Worksheet A-8 as adjustments to hospital costs;
iii. they are otherwise allowable and auditable provider costs; and
iv. they are further adjusted-for any non-patient-care activities such as research based on physician time studies.

If these are removed as A-8 adjustments to the hospital's general service cost centers, these costs should be stepped down to the physician cost centers based on the accumulated physician professional compensation costs. Other than the physician and non-physician practitioner compensation costs and the A-8 physician-related adjustments discussed above, no other costs are allowed for the purposes of this Exhibit of Attachment 4.19-B.

g. Total billed professional charges by cost center related to physician services are identified from hospital records. Similarly, for each non-physician practitioner type, the total covered professional charges are identified from hospital records.

h. A physician cost to charge ratio for each cost center is calculated by dividing the total costs for each cost center as established in paragraphs A-F of this Section by the total billed professional charges for each cost center as established in paragraph G of this section.

i. For each non-physician practitioner type, a cost to charge ratio is calculated by dividing the total costs for each cost center as established in paragraphs A-F of this Section by the total billed professional charges for each cost center as established in paragraph G of this section.

j. The total professional charges for each cost center related to covered Medicaid FFS physician services, billed directly by the hospital, are identified using claims data from the State's MMIS claims system. Other Medicaid professional charges are identified using claims data from the provider's records. Because the professional services are based on CPT codes and not track claims on a cost center basis, hospitals must map the claims to their cost centers using information from their hospital billing systems. Each charge may only be mapped to one cost center to prevent duplicate mapping and claiming.

k. For each non-physician practitioner type, the covered Medicaid FFS professional charges, billed directly by the hospital, are identified using claims data from State's MMIS claims system. Other Medicaid non-physician practitioner professional charges are identified using claims data from the provider's records. Because the professional services are based on CPT codes and not track claims on a cost center basis, hospitals must map the charges to non-physician practitioner type using information from their hospital billing systems. Each charge may only be mapped to one practitioner type to prevent duplicate mapping and claiming.

l. The total Medicaid costs related to physician practitioner professional services are determined for each cost center by multiplying total Medicaid charges as established in paragraph J by the respective cost to charge ratio for the cost center as established in paragraph H.

m. For each non-physician practitioner type, the total Medicaid costs related to non-physician practitioner professional services are determined by multiplying total Medicaid charges as established in paragraph K by the respective cost to charge ratios as established in paragraph I.

n. The total Medicaid unreimbursed costs are determined by subtracting all Medicaid FFS physician/practitioner payments received from the Medicaid costs as established in paragraphs L and M of this Section.

2. Ambulance Services

a. The ambulance services cost identified from each hospital's most recently filed CMS Form 2552-96 or future version of cost report Worksheet C Part I, Line 65 Column 1.

b. The ambulance services cost related to graduate medical education activities that are reported on Worksheet B Part I Line 65 Column 22 and 23.

c. Total billed ambulance service charges are identified from each hospital's most recently filed CMS Form 2552-96 or future version of cost report Worksheet C Part I, Line 65 Column 8.

d. A cost to charge ratio is calculated by dividing the total costs for

each cost center as established in paragraphs A and B of this Section by the total billed charges for each cost center as established in paragraph C.

e. The total charges for covered Medicaid ambulance services, billed directly by the hospital, are identified using claims data from the State's MMIS claims system. Other Medicaid ambulance charges are identified using claims data from the provider's records.

f. The total Medicaid costs related to hospital based ambulance services are determined by multiplying total Medicaid ambulance service charges as established in paragraph E by the respective cost to charge ratio for the cost center as established in paragraph D.

g. The total Medicaid unreimbursed costs are determined by subtracting all Medicaid interim payments received from the Medicaid costs as established in paragraphs E of this Section.

3. Home Health Services

a. The home health agency cost identified from each hospital's most recently filed CMS Form 2552-96 or future version of cost report Worksheet H-6 Lines 1-6 (patient services) and Lines 15-16.2 (other patient services) Column 3. Excluding Medical Social Services.

b. The home health agency cost related to graduate medical education activities that are reported on Worksheet B Part I Line 71 Column 22 and 23. The graduate medical education activities cost will be allocated based on total cost on Worksheet H-6 Lines 1-6 to the appropriate cost center.

c. Total billed home health agency visits are identified from each hospital's most recently filed CMS Form 2552-96 or future version of cost report Worksheet H-6, Line 1-6 Column 4.

d. Total billed home heath agency charges are identified from each hospital's most recently filed CMS Form 2552-96 or future version of the cost report Worksheet H-6 Lines 15-16.2 Column 4.

e. A cost per visit is calculated by dividing total costs for each patient service cost center as established in paragraphs A and B of this section by the total visits as identified in paragraph C.

f. A cost to charge ratio is calculated by dividing the total costs for each other patient services cost center as established in paragraphs A and B of this section by the total billed charges for each cost center as established in paragraph D.

g. The total visits and charges for covered Medicaid home health services, billed directly by the hospital, are identified using paid claims data from the State's MMIS claims system. Other Medicaid home health visits and charges are identified using claims data from the provider's records.

h. The total Medicaid costs related to hospital based home health services are determined as follows:

i. Multiplying total Medicaid home health visits per patient service cost center as established in paragraph G by the respective cost per visit for the cost center as established in paragraph E.

ii. Multiplying total Medicaid home health charges per other patient service cost center as established in paragraph G by the respective cost to charge ratio for the cost center as established in paragraph F.

iii. The total Medicaid costs eligible to be certified by public hospitals are determined by subtracting all Medicaid interim payments received from the Medicaid costs as established in paragraph H of this Section.

4. Hospice Services

a. The hospice cost identified from each hospital's most recently filed CMS Form 2552-96 or future version of cost report Worksheet K-6 Lines 1 Column 4.

b. The hospice cost related to graduate medical education activities that are reported on Worksheet B Part I Line 93 Column 22 and 23.

c. Total billed hospice unduplicated days are identified from each hospital's most recently filed CMS Form 2552-96 or future version of cost report Worksheet K-6, Line 2 Column 4.

d. A cost per diem is calculated by dividing total costs as established

in paragraphs A and B of this section by the total unduplicated days as identified in paragraph C.

e. The total unduplicated days for covered Medicaid hospice services, billed directly by the hospital, are identified using claims data from the State's MMIS claims system. Other Medicaid hospice unduplicated days are identified using claims data from the provider's records.

f. The total Medicaid costs related to hospital based hospice services are determined by multiplying total Medicaid hospice unduplicated days as established in paragraph E by the cost per diem as established in paragraph D.

g. The total Medicaid costs eligible to be certified by public hospitals are determined by subtracting all Medicaid interim payments received from the Medicaid costs as established in paragraph F of this Section.

5. Pharmacy Prescription Services

a. The pharmacy cost identified from each hospital's most recently filed CMS Form 2552-96 or future version of cost report Worksheet C Part I Line 56 Column 5.

b. The pharmacy cost related to graduate medical education activities that are reported on Worksheet B Part I Line 56 Column 22 and 23.

c. Total billed pharmacy charges are identified from each hospital's most recently filed CMS Form 2552-96 or future version of the cost report Worksheet C Part I Line 56 Column 8.

d. A cost to charge ratio is calculated by dividing the total costs as established in paragraphs A and B of this section by the total billed charges for each cost center as established in paragraph C.

e. The total charges for covered Medicaid pharmacy prescription services, billed directly by the hospital, are identified using claims data from the State's MMIS claims system. Other Medicaid pharmacy prescription service charges are identified using claims data from the provider's records.

f. The total Medicaid costs related to hospital based pharmacy

prescription services are determined by multiplying total Medicaid covered charges as established in paragraph E by the cost to charge ratio as established in paragraph D.

g. The total Medicaid costs eligible to be certified by public hospitals are determined by subtracting all Medicaid interim payments received from the Medicaid costs as established in paragraph F of this Section.

6. Durable Medical Equipment

a. The durable medical equipment cost identified from each hospital's most recently filed CMS Form 2552-96 or future version of cost report Worksheet C Part I Line 66 and 67 Column 5.

b. The durable medical equipment cost related to graduate medical education activities that are reported on Worksheet B Part I Line 66 and 67 Column 22 and 23.

c. Total billed durable medical equipment charges are identified from each hospital's most recently filed CMS Form 2552-96 or future version of the cost report Worksheet C Part I Line 66 and 67 Column 8.

d. A cost to charge ratio is calculated by dividing the total costs as established in paragraphs A and B of this section by the total billed charges for each cost center as established in paragraph C.

e. The total charges for covered Medicaid durable medical equipment, billed directly by the hospital, are identified using claims data from the State's MMIS claims system. Other Medicaid durable medical equipment charges are identified using claims data from the provider's records.

f. The total Medicaid costs related to hospital based durable medical equipment are determined by multiplying total Medicaid covered charges as established in paragraph E by the cost to charge ratio as established in paragraph D.

g. The total Medicaid costs eligible to be certified by public hospitals are determined by subtracting all Medicaid interim payments received from the Medicaid costs as established in paragraph F of this Section.

7. Renal Dialysis Services

   a. The outpatient renal dialysis services cost identified from each hospital's most recently filed CMS Form 2552-96 or future version of cost report Worksheet I-4 Lines 1-10 Column 2.

   b. The outpatient renal dialysis services cost related to graduate medical education activities that are reported on Worksheet B Part I Line 57 and 64 Column 22 and 23. Graduate medical education activities will be allocated on a percent to total of cost for each cost center reported on Worksheet I-4.

   c. Total billed outpatient renal dialysis treatments/patient weeks for each cost center are identified from each hospital's most recently filed CMS Form 2552-96 or future version of the cost report Worksheet I-4 Lines 1-10 Column 4.

   d. A cost per treatment/cost per patient week is calculated by dividing the total costs as established in paragraphs A and B of this section by the total billed treatments/patient weeks for each cost center as established in paragraph C.

   e. The total treatments/patient weeks for covered Medicaid outpatient renal dialysis services, billed directly by the hospital, are identified using claims data from the State's MMIS claims system. Other Medicaid treatments/patient weeks will be identified using claims data from provider's records.

   f. The total Medicaid costs related to hospital based outpatient renal dialysis services are determined by multiplying total Medicaid covered treatments/patient weeks as established in paragraph E by the cost per treatment/cost per patient week as established in paragraph D.

   g. The total Medicaid costs eligible to be certified by public hospitals are determined by subtracting all Medicaid interim payments received from the Medicaid costs as established in paragraph F of this Section.

8. Rural Health Center/Federal Qualified Health Center

   a. The rural health center/federal qualified health center cost identified from each hospital's most recently filed CMS Form

2552-96 or future version of cost report as follows:

i. Worksheet M-3 Part I Line 3 Column 1 for allowable cost excluding vaccines

ii. Worksheet M-4 Part I Line 10 Column 1 for cost of pneumococcal vaccine injections

iii. Worksheet M-4 Part 1 Line 10 Column 2 for cost of influenza vaccine injections

b. The rural health center/federal qualified health center cost related to graduate medical education activities that are reported on Worksheet B Part I Line 63 Column 22 and 23.

c. Total billed rural health center/federal qualified health center visits/vaccines are identified from each hospital's most recently filed CMS Form 2552-96 or future version of the cost report as follows:

i. Worksheet M-3 Part I Line 6 Column 1 for total adjusted clinic visits

ii. Worksheet M-4 Part I Line 11 Column 1 for total number of pneumococcal vaccine injections

iii. Worksheet M-4 Part 1 Line 11 Column 2 for total number of influenza vaccine injections

d. A cost per visit/cost per vaccine ratio is calculated by dividing the total costs as established in paragraphs A and B of this section by the total billed visits/vaccine injections for each cost center as established in paragraph C.

e. The total visits and vaccines for covered Medicaid rural health center/federal qualified health center, billed directly by the hospital, are identified using claims data from the State's MMIS claims system. Other Medicaid visits and vaccines will be identified using claims data from provider's records.

f. The total Medicaid costs related to hospital based rural health center/federal qualified health center are determined by multiplying total Medicaid covered visits/vaccine injections as

established in paragraph E by the cost per visit/cost per vaccine injection ratio as established in paragraph D.

g. The total Medicaid costs eligible to be certified by public hospitals are determined by subtracting all Medicaid interim payments received from the Medicaid costs as established in paragraph F of this Section.

h. Combining the cost of Medicaid routine services, cost of Medicaid inpatient ancillary services, cost of Medicaid outpatient ancillary services, cost of Medicaid outpatient other services, and the cost of Medicaid organ acquisition costs to determine the total Medicaid cost of services.

i. The payments received related to Medicaid services provided during the reporting period will be total Medicaid cost of services to determine the Medicaid uncompensated care.

Uncompensated cost of care for services provided to individuals with no source of third party insurance shall be calculated as follows:

a. Offsetting recoveries from individuals with no source of third party insurance against charges related to individuals with no source of third party insurance prior to applying charges against cost per diems and cost to charge ratios.

b. Applying the inpatient routine charges for individuals with no source of third party insurance from provider records to the applicable cost per diem per the Medicaid Worksheet D-1 to determine uninsured routine cost.

c. Applying the inpatient ancillary charges for individuals with no source of third party insurance from provider records to the applicable cost to charge ratio per the Medicaid Worksheet D-4 to determine uninsured inpatient ancillary cost.

d. Applying the outpatient ancillary charges for individuals with no source of third party insurance from provider records to the applicable cost to charge ratio per the Medicaid Worksheet D Part V to determine uninsured outpatient ancillary cost.

e. Determining the cost of uninsured organ acquisition cost for any transplants identified for individuals with no source of third party insurance.

f. Determining the cost of other outpatient services for individuals with no third party insurance for services defined in Attachment 3.1-A paragraph 2.d as follows:

1. Physician Services

a. The professional component of physician costs are identified from each hospital's most recently filed CMS Form 2552-96 or future version of cost report Worksheet A-8-2, Column 4.

These professional costs meeting the following requirements:

i. Limited to allowable and auditable physician compensations that have been incurred by the hospital;

ii. For the professional, direct patient care furnished by the hospital's physicians in all applicable sites of service.

iii. Identified as professional costs on Worksheet A-8-2, Column 4 of the cost report of the hospital claiming payment

iv. Supported by a time study, accepted by Medicare for Worksheet A-8-2 reporting purposes, that identified the professional, direct patient care activities of the physicians (not applicable to registry physicians discussed above)

v. Removed from hospital costs on Worksheet A-8.

b. The professional costs on Worksheet A-8-2, Column 4 are subject to further adjustments and offsets, including any necessary adjustment to bring the costs in line with Medicare cost principles. However, Medicare physician reasonable compensation equivalents are not applied for Medicaid physician professional cost determination purposes. There will be revenue offsets to account for revenues received for services by such professionals to non-patients (patients whom the hospital does not directly bill for) and any other applicable non-patient care revenues that were not previously offset or accounted for by the application of time study.

c. Reimbursement for other professional practitioner service costs

that have also been identified and removed from hospital costs on the CMS Form 2552-96 or future version of cost report. The practitioner types to be included are:

i. Nurse Practitioners
ii. Physician Assistants
iii. Dentists
iv. Certified Nurse Midwives
v. Clinical Social Workers
vi. Clinical Psychologists
vii. Optometrists

d. To the extent these practitioners' professional compensation costs are not included in Worksheet A-8-2, Column 4, but are removed from hospital costs through an A-8 adjustment on the CMS Form 2552-96 or future version of cost report, these costs may be recognized if they meet the following criteria:

i. the practitioners must engage in the direct provision of care in addition to being Medicaid-qualified practitioners for whom the services are billable under Medicaid separate from hospital services;
ii. for all non physician practitioners there must be an identifiable and auditable data source by practitioner type;
iii. a CMS-approved time study must be employed to allocate practitioner compensation between clinical and non-clinical costs as required under CMS Publication 15-II for completion of Worksheet A-8-2;
iv. the clinical costs resulting from the CMS-approved time study are subject to further adjustments and offsets, including adjustments to bring the costs in line with Medicare cost principles and offset of revenues received for services by such practitioners to non-patients (patients for whom the hospital does not directly bill for) and other applicable non-patient care revenues that were not previously offset or accounted for by the application of CMS-approved time study.

The resulting net clinical non-physician practitioner compensation costs are allowable costs for this Exhibit of Attachment 4.19-B. The compensation costs for each non-physician practitioner type are identified separately.

e. Professional costs incurred for freestanding clinics (clinics that

are not recognized as hospital outpatient departments on the CMS Form 2552-96 or future version of) are separately reimbursable as clinic costs and therefore should not be included in this protocol.

f. Hospitals may additionally include physician support staff compensation, data processing, and patient accounting costs as physician-related costs to the extent that these costs are removed from hospital inpatient and outpatient costs because

   i. they have been specifically identified as costs related to physician professional services;
   ii. they are directly identified on Worksheet A-8 as adjustments to hospital costs;
   iii. they are otherwise allowable and auditable provider costs; and
   iv. they are further adjusted-for any non-patient-care activities such as research based on physician time studies.

   If these are removed as A-8 adjustments to the hospital's general service cost centers, these costs should be stepped down to the physician cost centers based on the accumulated physician professional compensation costs. Other than the physician and non-physician practitioner compensation costs and the A-8 physician-related adjustments discussed above, no other costs are allowed for the purposes of this Exhibit of Attachment 4.19-B.

g. Total billed professional charges by cost center related to physician services are identified from hospital records. Similarly, for each non-physician practitioner type, the total covered professional charges are identified from hospital records.

h. A physician cost to charge ratio for each cost center is calculated by dividing the total costs for each cost center as established in paragraphs a-f of this Section by the total billed professional charges for each cost center as established in paragraph g of this section.

i. For each non-physician practitioner type, a cost to charge ratio is calculated by dividing the total costs for each cost center as established in paragraphs a-f of this section by the total billed

professional charges for each cost center as established in paragraph g of this section.

j. The total professional charges for each cost center related to covered physician services for individuals with no third party source of insurance are identified using claims data from the provider's records. Because physician claim data is based on CPT codes and does not track claims on a cost center basis, hospitals must map the claims to their cost centers using information from their hospital billing systems. Each charge may only be mapped to one cost center to prevent duplicate mapping and claiming. These charges must be associated with covered claims for services furnished during the period covered by the latest as-filed cost report.

k. For each non-physician practitioner type, the covered professional charges for individuals with no third party source of insurance are identified using claims data from the provider's records. Because non-physician professional claim data is based on CPT codes and may not track claims by non-physician practitioner type, hospitals must map the charges to non-physician practitioner type using information from their hospital billing systems. Each charge may only be mapped to one practitioner type to prevent duplicate mapping and claiming. These charges must be associated with covered claims for services furnished during the period covered by the latest as-filed cost report.

l. The total costs for individuals with no third party source of insurance related to physician practitioner professional services are determined for each cost center by multiplying total provider reported charges as established in paragraph j by the respective cost to charge ratio for the cost center as established in paragraph h.

m. For each non-physician practitioner type, total costs for individuals with no third party source of insurance related to non-physician practitioner professional services are determined by multiplying total provider reported charges as established in paragraph k by the respective cost to charge ratios as established in paragraph i.

n. The total uncompensated costs for individuals with no third

party source of insurance related to physician and non-physician practitioner professional services are determined by subtracting all physician and non-physician practitioner payments received on accounts for individuals with no source of third party insurance from the total costs as established in paragraphs l and m of this Section.

2. Ambulance Services

   a. The ambulance services cost identified from each hospital's most recently filed CMS Form 2552-96 or future version of cost report Worksheet C Part I, Line 65 Column 1.

   b. The ambulance services cost related to graduate medical education activities that are reported on Worksheet B Part I Line 65 Column 22 and 23.

   c. Total billed ambulance service charges are identified from each hospital's most recently filed CMS Form 2552-96 or future version of cost report Worksheet C Part I, Line 65 Column 8.

   d. A cost to charge ratio is calculated by dividing the total costs for each cost center as established in paragraphs a and b of this section by the total billed charges for each cost center as established in paragraph c.

   e. The total charges for ambulance services for individuals with no source of third party insurance as identified using provider's records for the applicable cost reporting period(s) within Medicaid State Plan rate year.

   f. The total costs related to hospital based ambulance services for individuals with no source of third party insurance are determined by multiplying total ambulance service charges as established in paragraph e by the respective cost to charge ratio for the cost center as established in paragraph d.

   g. The total uncompensated costs related to hospital based ambulance services for individuals with no source of third party insurance are determined by subtracting all payments received on accounts identified as individuals with no source of third party insurance from the total costs as established in paragraphs f of this Section.

3. Home Health Services

   a. The home health agency cost identified from each hospital's most recently filed CMS Form 2552-96 or future version of cost report Worksheet H-6 Lines 1-6 (patient services) and Lines 15-16.2 (other patient services) Column 3. Excluding Medical Social Services.

   b. The home health agency cost related to graduate medical education activities that are reported on Worksheet B Part I Line 71 Column 22 and 23. The graduate medical education activities cost will be allocated based on total cost on Worksheet H-6 Lines 1-6 to the appropriate cost center.

   c. Total billed home health agency visits are identified from each hospital's most recently filed CMS Form 2552-96 or future version of cost report Worksheet H-6, Line 1-6 Column 4.

   d. Total billed home heath agency charges are identified from each hospital's most recently filed CMS Form 2552-96 or future version of the cost report Worksheet H-6 Lines 15-16.2 Column 4.

   e. A cost per visit is calculated by dividing total costs for each patient service cost center as established in paragraphs a and b of this section by the total visits as identified in paragraph c.

   f. A cost to charge ratio is calculated by dividing the total costs for each other patient services cost center as established in paragraphs a and b of this section by the total billed charges for each cost center as established in paragraph d.

   g. The total visits and charges for home health services for individuals with no source of third party insurance are identified using claims data from the provider's records.

   h. The total costs for individuals with no source of third party insurance related to hospital based home health services are determined as follows:

      i. Multiplying total home health visits for individuals with no source of third party insurance per patient service cost center as established in paragraph g by the respective cost per visit for the cost center as established in paragraph e.

      ii. Multiplying total home health charges for individuals with no source of third party insurance per other patient service cost center as established in paragraph g by the respective cost to charge ratio for the cost center as established in paragraph f.

iii. The total uncompensated costs for individuals with no source of third party insurance eligible to be certified by public hospitals are determined by subtracting all payments received on accounts for individuals with no source of third party insurance from the costs as established in paragraph h of this section.

4. Hospice Services

   a. The hospice cost identified from each hospital's most recently filed CMS Form 2552-96 or future version of cost report Worksheet K-6 Lines 1 Column 4.

   b. The hospice cost related to graduate medical education activities that are reported on Worksheet B Part I Line 93 Column 22 and 23.

   c. Total billed hospice unduplicated days are identified from each hospital's most recently filed CMS Form 2552-96 or future version of cost report Worksheet K-6, Line 2 Column 4.

   d. A cost per diem is calculated by dividing total costs as established in paragraphs a and b of this section by the total unduplicated days as identified in paragraph c.

   e. The total unduplicated days for hospice services for individuals with no source of third party insurance are identified using claims data from the provider's records.

   f. The total costs for individuals with no source of third party insurance related to hospital based hospice services are determined by multiplying total hospice unduplicated days as established in paragraph e by the cost per diem as established in paragraph d.

   g. The total costs for individuals with no source of third party insurance eligible to be certified by public hospitals are determined by subtracting all payments on accounts for individuals with no source of third party insurance received from the costs as established in paragraph f of this Section.

5. Pharmacy Prescription Services

   a. The pharmacy cost identified from each hospital's most recently filed CMS Form 2552-96 or future version of cost report Worksheet C Part 1 Line 56 Column 5.

   b. The pharmacy cost related to graduate medical education activities that are reported on Worksheet B Part I Line 56 Column 22 and 23.

c. Total billed pharmacy charges are identified from each hospital's most recently filed CMS Form 2552-96 or future version of the cost report Worksheet C Part I Line 56 Column 8.

d. A cost to charge ratio is calculated by dividing the total costs as established in paragraphs a and b of this section by the total billed charges for each cost center as established in paragraph c.

e. The total charges for pharmacy prescription services for individuals with no source of third party insurance are identified using claims from provider's records.

f. The total costs for individuals with no source of third party insurance related to hospital based pharmacy prescription services are determined by multiplying total charges as established in paragraph e by the cost to charge ratio as established in paragraph d.

g. The total uncompensated care costs for individuals with no source of third party insurance eligible to be certified by public hospitals are determined by subtracting all payments received for accounts for individuals with no source of third party insurance from the costs as established in paragraph f of this Section.

6. Durable Medical Equipment

a. The durable medical equipment cost identified from each hospital's most recently filed CMS Form 2552-96 or future version of cost report Worksheet C Part I Line 66 and 67 Column 5.

b. The durable medical equipment cost related to graduate medical education activities that are reported on Worksheet B Part I Line 66 and 67 Column 22 and 23.

c. Total billed durable medical equipment charges are identified from each hospital's most recently filed CMS Form 2552-96 or future version of the cost report Worksheet C Part I Line 66 and 67 Column 8.

d. A cost to charge ratio is calculated by dividing the total costs as established in paragraphs a and b of this section by the total billed charges for each cost center as established in paragraph c.

e. The total charges for individuals with no source of third party insurance for durable medical equipment are identified using claims data from the provider's records.

f. The total costs for individuals with no source of third party insurance related to hospital based durable medical equipment are determined by multiplying total charges as established in paragraph e by the cost to charge ratio as established in paragraph d.

g. The total costs for individuals with no source of third party insurance eligible to be certified by public hospitals are determined by subtracting all payments on accounts for individuals with no source of third party insurance received from the costs as established in paragraph f of this section.

7. Renal Dialysis Services

a. The outpatient renal dialysis services cost identified from each hospital's most recently filed CMS Form 2552-96 or future version of cost report Worksheet I-4 Lines 1-10 Column 2.

b. The outpatient renal dialysis services cost related to graduate medical education activities that are reported on Worksheet B Part I Line 57 and 64 Column 22 and 23. Graduate medical education activities will be allocated on a percent to total of cost for each cost center reported on Worksheet I-4.

c. Total billed outpatient renal dialysis treatments/patient weeks for each cost center are identified from each hospital's most recently filed CMS Form 2552-96 or future version of the cost report Worksheet I-4 Lines 1-10 Column 4.

d. A cost per treatment/cost per patient week is calculated by dividing the total costs as established in paragraphs a and b of this section by the total billed treatments/patient weeks for each cost center as established in paragraph c.

e. The total treatments/patient weeks for outpatient renal dialysis services for individuals with no source of third party insurance are identified using claims data from the provider's records.

f. The total costs for individuals with no source of third party insurance related to hospital based outpatient renal dialysis services are determined by multiplying total treatments/patient weeks as established in paragraph e by the cost per treatment/cost per patient week as established in paragraph d.

g. The total uncompensated costs for individuals with no source of third party insurance eligible to be certified by public hospitals are determined by subtracting all payments received on accounts for

individuals with no source of third party insurance from the costs as established in paragraph f of this Section.

8. Rural Health Center/Federal Qualified Health Center

   a. The rural health center/federal qualified health center cost identified from each hospital's most recently filed CMS Form 2552-96 or future version of cost report as follows:

      i. Worksheet M-3 Part I Line 3 Column 1 for allowable cost excluding vaccines

      ii. Worksheet M-4 Part I Line 10 Column 1 for cost of pneumococcal vaccine injections

      iii. Worksheet M-4 Part 1 Line 10 Column 2 for cost of influenza vaccine injections

   b. The rural health center/federal qualified health center cost related to graduate medical education activities that are reported on Worksheet B Part I Line 63 Column 22 and 23.

   c. Total billed rural health center/federal qualified health center visits/vaccines are identified from each hospital's most recently filed CMS Form 2552-96 or future version of the cost report as follows:

      i. Worksheet M-3 Part I Line 6 Column 1 for total adjusted clinic visits

      ii. Worksheet M-4 Part I Line 11 Column 1 for total number of pneumococcal vaccine injections

      iii. Worksheet M-4 Part 1 Line 11 Column 2 for total number of influenza vaccine injections

   d. A cost per visit/cost per vaccine ratio is calculated by dividing the total costs as established in paragraphs a and b of this section by the total billed visits/vaccine injections for each cost center as established in paragraph c.

   e. The total visits and vaccines for rural health center/federal qualified health center for individuals with no source of third party insurance are identified using claims data from the provider's records.

   f. The total costs for individuals with no source of third party insurance related to hospital based rural health center/federal qualified health center are determined by multiplying total visits/vaccine injections as

established in paragraph e by the cost per visit/cost per vaccine injection ratio as established in paragraph f.

g. The total uncompensated costs for individuals with no source of third party insurance eligible to be certified by public hospitals are determined by subtracting all payments on accounts for individuals with no source of third party insurance received from the costs as established in paragraph f of this Section.

h. Combining the cost of uninsured routine services, cost of uninsured inpatient ancillary services, cost of uninsured outpatient ancillary services, cost of uninsured other outpatient services, and the cost of uninsured organ acquisition costs to determine the total cost of services provided to individuals with no source of third party insurance.

i. The payments received during the reporting period related to accounts of individuals with no source of third party will be used to total cost of services to determine the uncompensated cost of care of services provided to individuals with no source of third party insurance.

The uncompensated care of services for individuals with no source of third party insurance will be combined with the uncompensated cost of care for services provided to Medicaid eligible individuals to determine the uncompensated care cost. Any Medicaid payments in excess of Medicaid cost will be used to offset uncompensated care of services for individuals with no source of third party insurance.

The State will compare the interim reconciliation to initial DSH limit for each hospital. Any difference to the reimbursement amount will be recorded as an adjustment on the CMS 64 report.

5. Final Reconciliation of Interim Disproportionate Share Hospital (DSH) Limit Post Reporting Year: Upon issuance of a Notice of Program Reimbursement for CMS Form 2552-96 cost report(s) that incorporate the State fiscal year, each hospital's interim reconciliation will be reconciled to its CMS Form 2552-96 cost report as adjusted by the fiscal intermediary (FI) for purposes of Medicare reimbursement for the respective cost reporting period(s). For hospitals that have a cost reporting period that differs from the State fiscal year end date of September 30th, the cost reports that overlap the State fiscal year will be used for the calculation.

Prior to calculation of cost to charge ratios and cost per diems for final reconciliation for Medicaid eligible individuals, the Worksheet A-6 reclassification and Worksheet A-8 adjustment related to certified registered nurse anesthetists (CRNA) will be reversed on each hospital's CMS Form 2552-96 cost

report. In addition, the inpatient and outpatient charges related to CRNAs will have to be obtain from each hospital's financial records and included on Worksheet C for a proper calculation of cost to charge ratios including CRNA for inpatient services due to the State not reimbursing separately for hospital employed CRNAs for inpatient services.

Prior to calculation of cost to charge ratios for final reconciliation for individuals with no source of third party insurance, the following items will be completed in adapting the cost report.

a. The Worksheet A-6 reclassification and Worksheet A-8 adjustment related to certified registered nurse anesthetists (CRNA) will be reversed on each hospital's CMS 2552 cost report. In addition, the inpatient and outpatient charges related to CRNAs will have to be obtain from each hospital's financial records and included on Worksheet C for a proper calculation of cost to charge ratios including CRNA for inpatient services due to the State not reimbursing separately for hospital employed CRNAs for inpatient services.

b. The Worksheet A-8-1 adjustments will be reversed to allow cost to be reported at cost to the related party.

c. All non-professional services related adjustments on Worksheet A-8 will be removed from the cost report to allow cost to be reported with only adjustments related to professional services (excluding CRNA) will be used to offset cost.

If necessary changes are needed, the State will use MMIS for Fee For Service inpatient routine, inpatient ancillary, outpatient ancillary and outpatient other services days and charge information for each hospital. Also, each hospital will supply the State with detailed charge information for services provided to Medicaid eligible individuals not considered Fee For Service activity by the State for inpatient services, outpatient services, and outpatient other services. (ex. Out of State Medicaid, Managed Care) if additional charges have been identified since the interim reconciliation. Each hospital will supply detailed charge days and charges information for services provided to individuals with no source of third party insurance for inpatient services, outpatient services, and other outpatient services if additional accounts have been identified since the interim reconciliation.

The State will apply the cost per diems calculated on the Medicaid Worksheet D-1 Part II lines 38 and 42-47 to routine days that would be reported on Worksheet S-3 lines 5-11 and 14 to determine routine service cost and cost to charge ratios

calculated on the Medicaid Worksheet D-4 to inpatient ancillary charges related to CMS Lines 37-63 to determine inpatient ancillary service cost and cost to charge ratios calculated on the Medicaid Worksheet D Part V to outpatient ancillary charges related to CMS Lines 37-63 to determine outpatient ancillary service cost. CMS Form 2552-96 cost reporting schedules for outpatient other services will be used for calculation of cost as stated in paragraph e under the calculation of uncompensated cost of care for services provided to Medicaid eligible individuals and paragraph f under the calculation of uncompensated cost of care for services provided to individuals with no source of third party insurance. Medicaid cost per diems and cost to charges ratios, as well as outpatient other services cost calculations, shall include the cost of graduate medical education on Worksheet B Part I columns 22 and 23.

In addition to the cost calculated through application of cost per diems to routine service charges and cost to charge ratios to ancillary charges, a calculation of organ acquisition cost will be made for transplant approved hospitals eligible to certify public expenditures. The Worksheet D-6 series with the above modifications for each organ will be used to determine organ acquisition cost. The total amount of organ acquisition cost will be calculated as follows: Total organ acquisition cost per Worksheet D-6 Part III Line 53 divided by Total usable organs per Worksheet D-6 Part III Line 54 times number of organs transplanted during the year.

Uncompensated cost of care for services provided to Medicaid eligible individuals shall be calculated as follows:

a. Applying the inpatient routine Medicaid charges from provider records to the applicable cost per diem per the Medicaid Worksheet D-1 to determine Medicaid routine cost.

b. Applying the inpatient ancillary Medicaid charges from provider records to the applicable cost to charge ratio per the Medicaid Worksheet D-4 to determine Medicaid inpatient ancillary cost.

c. Applying the outpatient ancillary Medicaid charges from provider records to the applicable cost to charge ratio per the Medicaid Worksheet D Part V to determine Medicaid outpatient ancillary cost.

d. Determining the cost of Medicaid organ acquisition cost for any Medicaid transplants identified.

e. Determining the cost of uninsured other outpatient services based on methodology discussed under this protocol under paragraph e of the

uncompensated cost of care for services provided to Medicaid eligible individuals within the Interim Reconciliation of Interim Disproportionate Share Hospital (DSH) Limit Post Reporting Year section.

f. Combining the cost of Medicaid routine services, cost of Medicaid inpatient ancillary services, cost of Medicaid outpatient ancillary services, cost of Medicaid outpatient other services, and the cost of Medicaid organ acquisition costs to determine the total Medicaid cost of services.

g. The payments received related to Medicaid services provided during the reporting period will be total Medicaid cost of services to determine the Medicaid uncompensated care.

Uncompensated cost of care for services provided to individuals with no source of third party insurance shall be calculated as follows:

a. Offsetting recoveries from individuals with no source of third party insurance against charges related to individuals with no source of third party insurance prior to applying charges against cost per diems and cost to charge ratios.

b. Applying the inpatient routine charges for individuals with no source of third party insurance from provider records to the applicable cost per diem per the Medicaid Worksheet D-1 to determine uninsured routine cost.

c. Applying the inpatient ancillary charges for individuals with no source of third party insurance from provider records to the applicable cost to charge ratio per the Medicaid Worksheet D-4 to determine uninsured inpatient ancillary cost.

d. Applying the outpatient ancillary charges for individuals with no source of third party insurance from provider records to the applicable cost to charge ratio per the Medicaid Worksheet D Part V to determine uninsured outpatient ancillary cost.

e. Determining the cost of uninsured organ acquisition cost for any transplants identified for individuals with no source of third party insurance.

f. Determining the cost of uninsured other outpatient services based on methodology discussed under this protocol under paragraph f of the uncompensated cost of care for services provided to individuals with no source of third party insurance within the Interim Reconciliation of

Interim Disproportionate Share Hospital (DSH) Limit Post Reporting Year section:

g. Combining the cost of uninsured routine services, cost of uninsured inpatient ancillary services, cost of uninsured outpatient ancillary services, cost of uninsured other outpatient services, and the cost of uninsured organ acquisition costs to determine the total cost of services provided to individuals with no source of third party insurance.

h. The payments received during the reporting period related to accounts of individuals with no source of third party will be used to total cost of services to determine the uncompensated cost of care of services provided to individuals with no source of third party insurance.

The uncompensated care of services for individuals with no source of third party insurance will be combined with the uncompensated cost of care for services provided to Medicaid eligible individuals to determine the uncompensated care cost. Any Medicaid payments in excess of Medicaid cost will be used to offset uncompensated care of services for individuals with no source of third party insurance.

The State will compare the final reconciliation to the interim reconciliation for each hospital. Any difference to the reimbursement amount will be recorded as an adjustment on the CMS 64 report.