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

SEP - 1 2010

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

Attention: Robert Church

RE: TN 09-005

Dear Ms. Steckel:

We have reviewed the proposed amendment to Attachments 3.1-A, 4.19-A, 4.19-B, and 4.19-E of your Medicaid State plan submitted under transmittal number (TN) 09-005. Effective October 1, 2009 through September 30, 2011, this amendment proposes to revise the State's plan to reimburse public providers' cost for inpatient and outpatient hospital services using certified public expenditures (CPE) as the non-federal share of payments. In addition, this amendment proposes to revise the State's disproportionate share hospital (DSH) CPE methodology to include items previously noted by CMS as inconsistent with the DSH audit and reporting rule. The amendment proposes to reimburse private providers on a per diem basis with supplemental "access" payments that will not exceed the upper payment limit for private providers. The amendment proposes to remove the State's 16 day per calendar year inpatient coverage limit, and implement a 16 day reimbursement limit. Finally, the amendment eliminates the State's pre-paid health plan.

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. The proposed changes in payment methodology comply with applicable requirements and therefore are approved with an effective date of October 1, 2009. 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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 09-005

2. STATE: Alabama

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
October 1, 2009

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:
42 CFR 430 Subpart B

7. FEDERAL BUDGET IMPACT:
a. FFY 10 $256,002,352
b. FFY 11 $ 234,143,257

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A, pages 3A, 6H – 6J, 8D, 14, 20 - 23
Attachment 4.19-B, pages 8, 8.1, 8.2, and 15 - 18

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A, page 14
Attachment 4.19-B, pages 8 and 8.1

10. SUBJECT OF AMENDMENT: This amendment is needed to provide a change in the payment methodology for outpatient and inpatient hospital funding. An assessment will be taxed on private hospitals in Alabama and will be administered by the Department of Revenue. A Hospital Assessment account will be created in the Health Care Trust Fund and will require hospital assessments to be deposited in that account for use by the Alabama Medicaid Agency to obtain matching federal funds.

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//

13. TYPED NAME:
Carol Herrmann-Steckel

14. TITLE: Commissioner

15. DATE SUBMITTED:12-29-09

16. RETURN TO:
Carol A. Herrmann-Steckel
Commissioner
Alabama Medicaid Agency
501 Dexter Avenue
P.O. Box 5624
Montgomery, Alabama 36103-5624

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 12-30-09

18. DATE APPROVED: 09-01-10

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 10-01-09

20. SIGNATURE OF REGIONAL OFFICIAL:
//s//

21. TYPED NAME:
Cindy Mann

22. TITLE: Director, CMCS

23. REMARKS:

Approved with the following changes to item 7, 8 and 9 as authorized by State Agency e-mail dated 08/26/10

Block # 7 FFY 10 $285,312,235; FFY 11 $$259,400,858.

Block # 8 changed to read: Attachment 3.1-A page 1; Attachment4.19-A pages 3A, 6h,6i,6j ,8F, 14 20, 20.1 thru 20.20; Attachment 4.19-B pages 8,8.1,8.2,15, 15.1 thru 15.27 and 4.19-E page 1.

Block# 9 changed to read: Attachment 3.1-A page 1; Attachment 4.19-A page 14; Attachment 4.19-B page 8.1 and 4.19-E page 1.

State/Territory: Alabama

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

1. Inpatient hospital services other than those provided in an institution for mental diseases.

   Provided: /X/ No limitations /_/ With limitations* **

2.a. Outpatient hospital services.

   Provided: /_/ No limitations /X/ With limitations* **

b. Rural health clinic services and other ambulatory services furnished by a rural health clinic. (Which are otherwise included in the State Plan). ##

   /X/ Provided: /_/ No limitations /X/ With limitations* **

   /_/ Not provided.

c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).

   Provided: /_/ No limitations /X/ With limitations* **

d. This item deleted as per HCFA-PITN-MCD-4-92

3. Other laboratory and x-ray services.

   Provided: /_/ No limitations /X/ With limitations* **

##Via HCFA-PITN-MCD-4-02
#Limitations are the same as defined in 2.c above.

**Additional medically necessary services beyond limitations are

covered for children under 21 years of age referred through the E.P.S.D.T. Program.

*Description provided on attachment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE OF ALABAMA

METHOD FOR PAYMENT OF REASONABLE COSTS INPATIENT HOSPITAL SERVICES

Effective Date: 10/01/09

(m) Access Payment: A payment by the Medicaid program to an eligible hospital for inpatient and outpatient hospital care provided to a Medicaid recipient.

(n) Hospital: For purposes of Medicaid base, access and DSH payments for the period from October 1, 2009, through September 30, 2011, a facility, which is licensed as a hospital under the laws of the State of Alabama, provides 24-hour nursing services, and is primarily engaged in providing, by or under the supervision of doctors of medicine or osteopathy, inpatient services for the diagnosis, treatment, and care or rehabilitation of persons who are sick, injured, or disabled.

(o) Medicare Cost Report: The electronic cost report (ECR) filing of the CMS Form - 2552-96 Hospital and Hospital Health Care Complex Cost Report, as defined in CMS Provider Reimbursement Manual (PRM) 15-II (hereinafter referred to as " CMS Form 2552-96").

(p) Privately Owned and Operated Hospital: For purposes of Medicaid base, access and DSH payments for the period from October 1, 2009, through September 30, 2011, a hospital in Alabama other than:

(1) Any hospital that is owned and operated by the federal government;

(2) A hospital that is a state agency or unit of state government, including without limitation a hospital owned by a state agency or a state university.;

(3) A hospital created and operating under the authority of a governmental unit which has been established as a public corporation pursuant to Chapter 21 of Title 22 or Chapter 95 of Title 11, or a hospital otherwise owned and operated by a unit of local government, Alabama Code of 1975 22-21-1.

(4) A hospital that limits services to patients primarily to rehabilitation services as authorized by Alabama Administrative Code 410-2-4-.08; or

(5) A hospital granted a Certificate of Need as a Long Term Acute Care Hospital as defined by Alabama Administrative Code 410-2-4-.02(8).

(q) Non State Government Owned and Operated Hospital: For purposes of Medicaid base, access and DSH payments for the period from October 1, 2009, through September 30, 2011, a hospital in Alabama created or operating under the authority of a governmental unit which has been established as a public corporation pursuant to Ala. Code, Chapter 21 of Title 22 or Chapter 95 of Title 11, or a hospital otherwise owned or operated by a unit of local government. Also pursuant to Alabama Code of 1975 22-21-1.

(r) State Owned or Operated Hospital: For purposes of Medicaid base, access and DSH payments for the period from October 1, 2009, through September 30, 2011, a hospital in Alabama that is a state agency or unit of state government, including without limitation a hospital owned or operated by a state agency or a state university.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE OF ALABAMA

METHOD FOR PAYMENT OF REASONABLE COSTS INPATIENT HOSPITAL SERVICES

Effective Date: 10/01/09

(j) For the period October 1, 2009, through September 30, 2011, each hospital shall receive an inpatient Medicaid base (per diem) payment, in accordance with the following:

(1) Medicaid shall pay each hospital as a base (per diem) amount for state fiscal years 2010 and 2011 the total inpatient payments made by Medicaid to each hospital from all sources except DSH payments during state fiscal year 2007, divided by the total paid inpatient hospital days incurred by that hospital in state fiscal year 2007, multiplied by the inpatient hospital days incurred by each hospital during fiscal years 2010 and 2011.

(2) Base (per diem) payments for state fiscal years 2010 and 2011 will not be made to any non state government owned or operated Hospital owned, state owned or operated or privately owned or operated hospital that was in operation during the hospital's fiscal year ending in 2007 that ceases to operate as a hospital, beginning on the date that the facility ceases to operate as a hospital.

(3) Base (per diem) payments will be interim payments for hospitals that qualify for and file Certified Public Expenditures.

(4) Base (per diem) payments will be reviewed on quarterly basis to ensure that hospitals are not paid more than the 16 day reimbursement limit, per beneficiary, except for children under the age of one, or under the age of six who are receiving medically necessary inpatient services in a hospital which has been designated by Medicaid as a disproportionate share hospital, or who have been referred for treatment as the result of an EPSDT screening. Adjustments will be made to hospitals' interim payments to reflect the results of the reconciliation. Hospitals which are privately owned or operated will be reimbursed on the basis of a maximum sixteen day annual beneficiary limit, subject to a maximum reimbursement, equivalent to the current per diem amount multiplied times the covered days (limited to the 16 day annual beneficiary limit).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE OF ALABAMA

METHOD FOR PAYMENT OF REASONABLE COSTS INPATIENT HOSPITAL SERVICES

(k) For the period October 1, 2009, through September 30, 2011, the amount available for inpatient hospital access payments shall be calculated as follows:

(1) The state shall annually identify the total Medicaid inpatient hospital payments for privately operated hospitals for state fiscal year 2007 from all sources except DSH payments.

(2) The state shall estimate the amount that would have been paid for the services identified in step (1) using Medicare principles consistent with the upper payment limit (UPL) requirements set forth in 42 CFR 447.272.

(3) The state shall subtract step (1) from step (2) to determine the aggregate inpatient hospital access payment amount.

(l) For the period October 1, 2009, through September 30, 2011, in addition to any other funds paid to hospitals for inpatient hospital services to Medicaid patients, each eligible private hospital, excluding free-standing psychiatric hospitals, shall receive inpatient hospital access payments each state fiscal year. Inpatient hospital access payments shall include the following:

(1) An inpatient hospital access payment equal to the difference between the hospital's allowable cost of providing Medicaid inpatient hospital services for state fiscal year 2007, trended forward, and base payments for the current fiscal year.

(2) A payment for private hospitals that do not qualify for disproportionate share payments, calculated as follows:

(a) For hospitals with uninsured uncompensated care costs greater than $800,000 in state fiscal year 2007, a payment equal to $400 per Medicaid inpatient day.

(b) For hospitals with uninsured uncompensated care costs less than $800,000 in state fiscal year 2007, a payment equal to $100 per Medicaid inpatient day.

(3) These additional inpatient hospital access payments shall be made on a quarterly basis.

(4) When combined with base payments, inpatient hospital access payments shall not exceed the annual inpatient upper payment limit.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE OF ALABAMA

METHOD FOR PAYMENT OF REASONABLE COSTS INPATIENT HOSPITAL SERVICES

(m) For the period October 1, 2009, through September 30, 2011, in addition to any other funds paid to private free-standing psychiatric hospitals for inpatient hospital services to Medicaid patients, qualifying hospitals shall receive a private free-standing psychiatric hospital access payment equal to $185 per Medicaid inpatient day paid in state fiscal year 2007.

(n) For the period October 1, 2009, through September 30, 2011, Medicaid shall pay Bryce Hospital a base (per diem) payment based on 2007 inpatient payments divided by 2007 total Medicaid days trended by the hospital market basket index as published by *Global Insight Health-Care Cost Review* to determine the payments being calculated for the current fiscal year.

(o) For the period October 1, 2009, through September 30, 2011, With respect to Non State Government Owned and Operated Hospitals and State Owned Hospitals that are qualified to certify public expenditures, and do certify, in accordance with 42 CFR 433.51(b) an additional expenditures claimable for Federal Financial Participation (FFP) will be based on difference between the hospitals' reasonable costs incurred in serving Medicaid inpatients, as determined in accordance with Medicare principles outlined in Exhibit C of this attachment and the interim payments made under paragraph (j).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE OF ALABAMA

METHOD FOR PAYMENT OF REASONABLE COSTS INPATIENT HOSPITAL SERVICES

Effective Date: 10/01/09

(f) For the period from October 1, 2009, to September 30, 2011, the Alabama Medicaid Agency shall appropriate and expend the full disproportionate share allotment to hospitals under Section 1923(f)(3) of the Social Security Act (the Act) in a manner consistent with the hospital-specific DSH limits under section 1923(g) of the Act.

(1) Payments to disproportionate share hospitals shall be made to all hospitals qualifying for disproportionate hospital payments under Section 1923(d) and 1923 (b) of the Social Security Act.

(2) Medicaid shall pay qualifying public and state owned disproportionate share hospitals an amount equal to each hospital's allowable uncompensated care cost under the hospital specific DSH limit in Section 1923(g) of the Social Security Act for state fiscal year 2007. State owned institutions for mental disease shall receive no more than the same disproportionate share hospital payments the institutions received in state fiscal year 2009.

(3) Qualifying public and state owned disproportionate share hospitals as defined on Attachment 4.19-A Page 3A shall receive an amount such that the sum of net inpatient hospital base payments, net outpatient hospital base payments and disproportionate share payments are equal to the greater of 2007 total Medicaid inpatient, outpatient and DSH payments or ninety-five percent of allowable Medicaid costs.

(4) The disproportionate share hospital allotment remaining after disproportionate share hospital payments have been made to public and state owned hospitals shall be paid to private hospitals as defined on Attachment 4.19-A Page 3A. Disproportionate share hospital payments shall be paid to eligible private hospitals as follows:

(a) A payment equal to 7.93 percent of each hospital's eligible uncompensated care costs in state fiscal year 2007.

(b) A payment equal to each eligible hospital's pro rata share of the DSH allotment remaining following payment under subsection (a). The payment shall be based upon each hospital's eligible uncompensated care costs under the hospital specific DSH limit in Section 1923(g) of the Social Security Act during state fiscal year 2007, divided by the total eligible uncompensated care costs for all eligible private disproportionate share hospitals during state fiscal year 2007.

(5) Total disproportionate share hospital payments to each hospital shall be made during the first month of the state fiscal year.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE OF ALABAMA

METHOD FOR PAYMENT OF REASONABLE COSTS INPATIENT HOSPITAL SERVICES

Effective Date: 10/01/09

XVIII. OUT-OF-STATE HOSPITAL INPATIENT RATES

Payment for inpatient services provided by all out-of-state hospitals shall be the lesser of the submitted covered charges or the Alabama flat rate which shall be composed of the average of the per diem rate paid to out-of-state hospitals in FY 2009 inflated annually by the Global Insight.

Effective Date: 07/01/91

XIX. MEDICARE CATASTROPHIC COVERAGE ACT {Section 302(b) (2)} DAY AND COST OUTLIERS

(a) The Alabama Medicaid Agency has lifted the durational limits for medically necessary inpatient services provided to children under the age of 6 years in hospitals deemed by the Agency as disproportionate and under the age of 1 in all hospitals. Because we pay for all medically necessary days of care for these children, we meet the day outlier requirement.

(b) Cost Outliers

1. A cost outlier for an extremely costly length of stay for a child under age 6 receiving medically necessary services in a hospital deemed by the Alabama Medicaid Agency as disproportionate and under age 1 in all hospitals, is defined as a claim for payment for a discharged child for allowable services rendered from the date of admission to the date of discharge which meets the following criteria:

The Medicaid allowed charges per day for the length of stay for Medicaid eligible children as outlined above must exceed four times the hospital's mean total charge per day as established by Medicaid from Agency paid claim data.

2. Payment of Cost Outliers

The sum of allowed charges in excess of 4 times the mean total charge per day shall be multiplied by the hospital's current rate period percent of total Medicaid cost to total Medicaid charges (per Worksheet C of the Medicaid Cost Report) to establish the amount to be paid as a cost outlier. The outlier payment shall be limited to a total of $10,000 per discharge and $50,000 per infant during the per diem rate cycle July 1 through June 30.

EXHIBIT C
Page 1

Certified Public Expenditures 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 utilize Worksheet Series S, B and C to determine the cost 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 rate and supplemental 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 obtained 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, Part 1, Column 5, lines 5-11 to determine Medicaid routine service cost for acute services, the cost per diem calculated on Medicaid Worksheet D-1, Part II, line 38 for each subprovider with its respective days on worksheet S-3, Part 1, Column 5, line 14 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. The Medicaid days and charges are tied to MMIS paid claims data.

   In addition to the cost calculated through application of cost per diems to routine service

days 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 inclusion of medical education cost as state above 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 (fee for service) transplanted during the year.

Total Medicaid inpatient cost therefore will be the sum of routine service cost, ancillary service cost and organ acquisition cost. Any Medicaid payments (other than the interim payments provided in this protocol) and 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 payments made to the interim Medicaid cost computed here 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 obtained 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, Part 1, Column 5, lines 5-11 and 14 to determine Medicaid routine service cost for acute services, the cost per diem calculated on Medicaid Worksheet D-1, Part II, line 38 for each subprovider with its respective days on Worksheet S-3, Part 1, Column 5, line 14, 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. The Medicaid days and charges are tied to MMIS paid claims data.

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 inclusion of medical education cost as stated above 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 the number of Medicaid organs (fee for service) transplanted during the year.

Total Medicaid inpatient cost therefore will be the sum of routine service cost, ancillary service cost and organ acquisition cost. Any Medicaid payments other than the interim payments provided in this protocol and 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 Medicaid cost 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 cost of the uninsured and Medicaid cost not included in the State's MMIS (ex. Out of State Medicaid, unreimbursed hospital costs for otherwise Medicaid eligibles, and Medicaid Managed Care). The base year will be the State fiscal year beginning two years prior to the reporting year (ex. 2007 data for 2009 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 to Medicaid eligible individuals not identified for inclusion in the calculation of Medicaid cost per Attachment 4.19-A Exhibit C, Page 1, Item 1-4 and Attachment 4.19-B, Exhibit A, Page 1, Item 1.

   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. 2007 data for 2009 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 1, 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 covered charges not identified for inclusion in the calculation of Medicaid cost per Attachment 4.19-A Exhibit C, Page 1, Item 1 and Attachment 4.19-B, Exhibit A, Page 1, Item 1 will be multiplied by the CCR to determine Medicaid cost. Payments made related to these Medicaid covered 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 paid under the calculations for disproportionate share hospital payments as outlined in paragraph f of Attachment 4.19-A 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 obtained 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.

Due to Medicaid services as identified in Attachment 4.19-A Exhibit C, Page 1, Item 1-4 and Attachment 4.19-B, Exhibit A, Page 1, Item 1 for hospitals eligible to certify public expenditures being certified at cost, there will be no uncompensated care for these services.

Each hospital will supply the State with detailed days and charges information for services provided to Medicaid eligible individuals not identified for inclusion in the calculation of Medicaid cost per Attachment 4.19-A Exhibit C, Page 1, Item 1-4 and Attachment 4.19-B, Exhibit A, Page 1, Item 1 and for services provided to individuals with no source of third party insurance.

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, Part 1, Column 6, lines 5-11 to determine routine service cost for acute services, the cost per diem calculated on Medicaid Worksheet D-1, Part II, line 38 for each subprovider with its respective days included on Worksheet S-3, Part I, Column 6, line 14 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 to CMS line 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 days 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 inclusion of medical education cost as state above 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 to the applicable individuals 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 covered days for Medicaid services not included in the State's MMIS to the applicable cost per diem per the Medicaid Worksheet D-1 to determine Medicaid routine cost.

b. Applying the inpatient ancillary Medicaid covered charges for Medicaid services not included in the State's MMIS 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 covered charges for Medicaid services not included in the State's MMIS 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 Medicaid services for other outpatient services as defined in Attachment 3.1 paragraph 2.d for Medicaid services not included in the State's MMIS based on the protocol as outlined in Attachment 4.19-B, Exhibit A for physicians, home health services, durable medical equipment, hospice, pharmacy prescription services, renal dialysis, RHC/FQHC and ambulance which are not included in the cost calculations in paragraph a through c above.

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

g. The payments received related to Medicaid services provided during the reporting period will be offset against 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. Applying the inpatient routine days 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.

b. 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.

c. 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.

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

e. 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 health 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.

i. 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 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 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.

f. 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.

g. The payments received during the reporting period related to accounts of individuals with no source of third party will be used as offset 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 2552 cost report(s) that incorporate the State fiscal year, each hospital's interim reconciliation will be reconciled to its CMS 2552 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.

Due to Medicaid services as identified in Attachment 4.19-A Exhibit C Page 1, Item 1-4 and Attachment 4.19-B, Exhibit A, Page 1, Item 1, et. seq. for hospitals eligible to certify public expenditures being certified at cost, there will be no uncompensated care for these services.

If necessary, each hospital will supply the State with updated detailed days and charges information for services provided to Medicaid eligible individuals not identified for inclusion in the calculation of Medicaid cost per Attachment 4.19-A Exhibit C Page 1, Item 1 and Attachment 4.19-B, Exhibit A, Page 1, Item 1 and for services provided to

individuals with no source of third party insurance. The State will also update any payment offset if necessary.

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, Part 1, Column 6, lines 5-11 to determine routine service cost for acute services, the cost per diem calculated on Medicaid Worksheet D-1, Part II, line 38 for each subprovider with its respective days included on Worksheet S-3, Part 1, Column 6, line 14 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 days 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 inclusion of medical education cost as stated above 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 to the applicable individuals 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 days 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 Medicaid services for other outpatient services as defined in Attachment 3.1 paragraph 2.d for Medicaid services not included in the State's MMIS based on the protocol as outlined in Attachment 4.19B Exhibit A for physicians, home health services, durable medical equipment, hospice, pharmacy prescription services, renal dialysis, RHC/FQHC and ambulance which are not included in the cost calculations in paragraph a through c above.

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

g. The payments received related to Medicaid services provided during the reporting period will be offset against 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. Applying the inpatient routine days 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.

b. 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.

c. 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.

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

e. Determining the cost of uninsured other outpatient services based on methodology discussed under this protocol under paragraph e of the Interim Reconciliation of Interim Disproportionate Share Hospital (DSH) Limit Post Reporting Year:

f. 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.

g. The payments received during the reporting period related to accounts of individuals with no source of third party will be used as offset 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.

Provider Reimbursement Manual). Rates will be renegotiated upon mutual agreement between the agencies and will not exceed the allowable costs according to the principles for cost determination cited above.

Effective Date: 01/01/92

e. Covered Family Planning drugs prescribed (oral contraceptives and supplies) are paid pursuant to the method described in section 4 of this attachment.

Effective Date: 01/01/92

f. Covered Drugs prescribed for treatment of conditions identified and referred from an EPSDT examination are paid pursuant to the method described in section 4 of this attachment.

11. Ambulance Services

Effective Date: 09/01/05

Payment for ground or air (for children under the age of 21 years old) ambulance services shall be based on the lesser of the submitted charge or Alabama Medicaid's statewide ambulance service rates. Air transportation for adults 21 years of age and older will be reimbursed at the emergency ground rate. The amount to be paid to out-of-state providers shall be their usual and customary fees not to exceed the maximum allowable charges or benefits established by Medicaid.

12. Nurse-midwives

Payment to nurse-midwives shall be based on payments made to physicians for similar services. Payment to midwives shall fall somewhere between 50% and 85% of the amount paid to physicians.

13. Clinic Services Provided by Mental Health Service Providers

Effective Date: 01/01/84

Reimbursement will be at a negotiated rate, but not to exceed the costs which must be incurred by an efficient and economic provider of Mental Health Services.

14. Outpatient Hospital Services

Effective Date: 10/01/2009

a. Definitions Related to Payments for Outpatient Hospital Services

(1) Access Payment: A payment by the Medicaid program to an eligible hospital for outpatient hospital care provided to a Medicaid recipient.

(2) Hospital: For purposes of Medicaid base, access and DSH payments for the period from October 1, 2009, through September 30, 2011, a facility, which is licensed as a hospital under the laws of the State of Alabama, provides 24-hour nursing services, and is primarily engaged in providing, by or under the supervision of doctors of medicine or osteopathy, inpatient services for the diagnosis, treatment, and care or rehabilitation of persons who are sick, injured, or disabled.

(3) Medicare Cost Report: The electronic cost report (ECR) filing of the Form CMS-2552-96 Hospital and Hospital Health Care Complex Cost Report, as defined in CMS Provider Reimbursement Manual (PRM) 15-II (hereinafter referred to as "Form CMS 2552-96)

(4) Privately Owned or Operated Hospital: For purposes of Medicaid base, access and DSH payments for the period from October 1, 2009, through September 30, 2011, a hospital in Alabama other than:

(a) Any hospital that is owned and operated by the federal government;
(b) A hospital that is a state agency or unit of state government, including without limitation a hospital owned by a state agency or a state university.;
(c) A hospital created and operating under the authority of a governmental unit which has been established as a public corporation pursuant to Chapter 21 of Title 22 or Chapter 95 of Title 11, or a hospital otherwise owned and operated by a unit of local government pursuant to Code of Alabama of 1975, Section 22-21-1.
(d) A hospital that limits services to patients primarily to rehabilitation services as authorized by Alabama Administrative Code 410-2-4-.08; or
(e) A hospital granted a Certificate of Need as a Long Term Acute Care Hospital as defined by Alabama Administrative Code 410-2-4-.02(8).

(5) Non State Owned or Operated Government Hospitals: For purposes of Medicaid base, access and DSH payments for the period from October 1, 2009, through September 30, 2011, a hospital in Alabama created and operating under the authority of a governmental unit which has been established as a public corporation pursuant to Ala. Code, Chapter 21 of Title 22 or Chapter 95 of Title 11, or a hospital otherwise owned and operated by a unit of local government pursuant to Code of Alabama of 1975, Section 22-21-1.

(6) State Government Owned or Operated Hospital: For purposes of Medicaid base, access and DSH payments for the period from October 1, 2009, through September 30, 2011, a hospital in Alabama that is a state agency or unit of state government, including without limitation a hospital owned by a state agency or a state university.

b. Outpatient Medicaid Base Payments.

Medicaid shall pay each hospital as a base amount for state fiscal years 2010 and 2011 the total outpatient payments made by Medicaid to each hospital from all sources except DSH payments during state fiscal year 2007, divided by the total outpatient encounters (ICN count) incurred by that hospital in state fiscal year 2007, multiplied by the total outpatient encounters (ICN count) incurred by each hospital during fiscal years 2010 and 2011.

Payment for all out-of-state outpatient hospital services will be from approved rates, by procedure code. The Agency's rates were set as of October 1, 2009 and are effective for services on or after that date. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers and the fee schedule and any annual/periodic adjustments to the fee schedule are published on the Alabama Medicaid Agency's website (http://www.medicaid.alabama.gov/billing/fee_schedules.aspx?tab=6).

c. Outpatient Access Payments.

For the period from October 1, 2009, through September 30, 2011, in addition to any other funds paid to hospitals for outpatient hospital services to Medicaid patients, each eligible hospital, except for hospitals as outlined in d. below, shall receive outpatient hospital access payments each state fiscal year. The outpatient hospital access payment shall be calculated as follows:

(1) The state shall identify the total Medicaid outpatient hospital payments to privately operated hospitals for state fiscal year 2007.
(2) The state shall estimate the amount that would have been paid for the services identified in step (1) using Medicare principles consistent with the upper payment limit (UPL) requirements set forth in 42 CFR 447.321 (see UPL method in 14.e).
    a. The state shall subtract step (2) from step (1) to determine the aggregate outpatient hospital access payment amount.
    b. Each eligible privately owned or operated hospital, excluding private free-standing psychiatric hospitals, shall annually receive outpatient access payments equal to the difference between the hospital's allowable cost of providing Medicaid outpatient hospital services for state fiscal year 2007 and base payments for the current fiscal year.
(3) Outpatient hospital access payments shall be made on a quarterly basis.

d. Privately owned acute care hospitals, that meet the criteria in (1) and (2) below, shall be paid an enhanced payment not to exceed in the aggregate, the upper payment limit (UPL) as described in 42 CFR 447.321 (see UPL method in 14.e.).

(1) the hospital must be located in a county with a population greater than 200,000 (according to the latest U.S. census), and
(2) the hospital must participate in the county's largest city's outpatient/emergency room assistance program.

The enhanced payment to privately owned acute care hospitals, that meet the criteria in (1) and (2) above, excluding hospitals which predominately treat children under the age of 18 years, will be determined on an annual basis by Medicaid and divided evenly among qualified hospitals.

a. Using data derived from the Medicare cost report, Form CMS 2552-96, a ratio of Total costs to Total charges was calculated for each privately owned and operated hospital. All cost report data was from the 2007 cost reporting year. The cost-to-charge ratio was then applied to 2007 Medicaid outpatient charges to determine Medicaid outpatient cost. Medicaid outpatient charges include covered outpatient fee for service charges. 2007 Medicaid cost was inflated to 2010 using the market basket inflation amount of 3.3% from 2007 to 2010. Inflated 2010 Outpatient Medicaid UPL Cost is multiplied by 99.2% and reduced by the 2010 Estimated Medicaid Outpatient Payments to determine the UPL/Enhancement Payment.

EXHIBIT A
Page 1

Certified Public Expenditures incurred in providing services to Medicaid outpatient services

The Alabama Medicaid Agency uses the CMS Form 2552-96 or future version cost report for its Medicaid program and all acute care hospitals must submit this report each year. The Agency will determine Medicaid costs incurred by hospitals, but not including contractuals, to be certified as public expenditures (CPE) from the CMS Form 2552-96. The Agency will use the protocol below.

Cost of Medicaid

1. Interim Medicaid Outpatient Hospital Payment Rate Effective Beginning of Reporting Year: Using data derived from the cost report ending in calendar year 2007 for each hospital, a ratio of total costs to total charges was calculated for each hospital. The CMS 2552-96 cost report data was taken from Worksheet C, Part I, column 5, line 101 less lines 32, 34-36 and 62 (total cost), column 6, line 101 less lines 32 and 34-36 (inpatient charges), column 7, line 101 less lines 32 and 34-36 (outpatient charges) and column 8, line 101 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.

   The cost-to-charge ratio was then applied to 2007 Medicaid outpatient charges to determine Medicaid cost. Medicaid outpatient charges include covered Fee For Service billed amounts.

   2007 Medicaid cost was inflated to 2010 using the average annual cost increase for the State of Alabama from 2002 to 2007.

   An estimate of payments made per interim rate payment methodology per Attachment 4.19-B Page 8.1 paragraph b will be compared to the estimate of Medicaid cost to determine the additional expenditure claimed as an interim amount.

2. Additional Settlements/Medicaid Payments During Reporting Year: On a quarterly basis, Alabama Medicaid will monitor for a change in status of the cost report(s) for hospitals whose payments have been claimed as CPE. If there is a change in status of the cost report(s), Alabama Medicaid will recalculate the actual allowable CPE and compare it to the last CPE payments claimed on the CMS 64. This calculation will be made in accordance with Attachment 4.19-B

Exhibit A of the Alabama State Plan. In addition, the State will identify any additional Medicaid payments related to service dates in the payment year and will use such payment to as offsets to the CPE. Any overpayments are credited to the federal government. Any underpayments will be claimed from the federal government.

3. Interim Reconciliation of Interim Medicaid outpatient 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 or future version 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 or future version cost report that includes the September 30th fiscal year end of the State.

   The State will apply the cost to charge ratios calculated on the Medicaid Worksheet D Part V to ancillary charges related to CMS Lines 37-63 to determine Medicaid outpatient 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 covered outpatient charges include Fee For Service allowable amounts.

   Third party and client responsibility payments are deducted from the total Medicaid outpatient ancillary 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.

4. Final Reconciliation of Interim Medicaid Outpatient Hospital Payment Rate Post Reporting Year: Upon issuance of a Notice of Program Reimbursement for CMS 2552 cost report(s) that incorporate the State fiscal year, each hospital's interim reconciliation will be reconciled to its CMS Form 2552-96 or future version 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.

The State will apply the cost to charge ratios calculated on the Medicaid Worksheet D Part V to ancillary charges related to CMS Lines 37-63 to determine Medicaid outpatient 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 outpatient charges include covered Fee for Service allowable amounts. The Medicaid charges are tied to MMIS paid claims data.

All Medicaid payments and third party and client responsibility payments are deducted from the total Medicaid outpatient ancillary 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 Hospital Based Physician Services for State Government Owned and Operated Hospitals and Non State Owned or Operated Government Hospitals

This section describes the cost identification methodology for professional services provided at both State government owned or operated hospitals and non-State owned or operated government hospitals, for the uncompensated Medicaid costs of providing physician and non-physician practitioner professional services to Medicaid eligible beneficiaries. Only the otherwise uncompensated costs of professional services not claimed by the hospital as Medicaid inpatient hospital services under the hospital's provider number, or not otherwise recognized under the methodology set forth in Attachment 4.19-A and methodologies for reimbursement for government operated outpatient hospital services or government operated clinic services set forth in other sections of this Attachment 4.19-B, are eligible for reimbursement under this Exhibit of Attachment 4.19-B. Eligible professional costs are reported on the designated hospitals' Medicare CMS Form 2552-96 or future version of the cost report

1. General Reimbursement Requirements

A. The government-operated hospitals identified in this Exhibit, and the government operated entities with which they are affiliated, including their affiliated government-operated physician practice groups, are eligible providers that will certify the un-reimbursed Medicaid costs specified in Section C of this Exhibit, below.

B. Eligible providers will receive fee-schedule payments for professional services on an interim basis.

C. Notwithstanding any other provision of this State Plan, reimbursement for the otherwise uncompensated costs of Medicaid eligible services described in this Exhibit of Attachment 4.19-B, that are provided to Medicaid eligible patients by physicians and non-physician practitioners of government-operated hospitals or the government entities with which they are affiliated, will be governed by this Exhibit of Attachment 4.19-B.

D. Professional costs incurred by freestanding clinics that are not recognized as hospital outpatient departments on the CMS Form 2552-96 or future version of and are reimbursable for both the professional and technical components of the physician fee under Attachment 4.19B Section 3 are not included in this protocol. Professional costs incurred at clinics that operate on the hospital's license under state licensing laws will be included under this segment of Attachment 4.19-B to the extent they are not reimbursable for both the professional and technical components of the physician fee under Attachment 4.19-B Section 3.

2. Eligible Providers

The physician and non-physician practitioner professional costs being addressed in this protocol are limited to professional costs incurred by the governmental hospitals as defined under Attachment 4.19-B paragraphs 14a(5) and 14a(6). These professional costs are reported on the designated hospitals' CMS Form 2552-96 or future version cost report.

3. Reimbursement Methodology

This methodology will approximate the difference between the fee-for service (FFS) payment and the allowable Medicaid costs related to the professional component of physician or non-physician practitioner services eligible for Federal financial participation. This computation of establishing the interim Medicaid costs must be performed on an annual basis and in a manner consistent with the instructions below.

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:
(1) Limited to allowable and auditable physician compensations that have been incurred by the hospital;
(2) For the professional, direct patient care furnished by the hospital's physicians in all applicable sites of service;

(3) Identified as professional costs on Worksheet A-8-2, Column 4 of the cost report of the hospital claiming payment;

(4) 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);

(5) 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:

(1) Nurse Practitioners
(2) Physician Assistants
(3) Dentists
(4) Certified Nurse Midwives
(5) Clinical Social Workers
(6) Clinical Psychologists
(7) 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:

(1) 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;
(2) for all non physician practitioners there must be an identifiable and auditable data source by practitioner type;

(3) 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;
(4) 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
(1) they have been specifically identified as costs related to physician professional services;
(2) they are directly identified on Worksheet A-8 as adjustments to hospital costs;
(3) they are otherwise allowable and auditable provider costs; and
(4) 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 Section C of this Exhibit.

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. Because the MMIS claims system 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 Medicaid FFS professional charges, billed directly by the hospital, are identified using claims data from State's MMIS claims system. Because the MMIS claims system 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 Medicaid costs related to physician practitioner professional services are determined for each cost center by multiplying total Medicaid FFS 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 FFS 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.

The amount of the unreimbursed Medicaid cost will be based on the Medicaid fee schedule payments and costs for the period coinciding with the latest as-filed cost report; the data sources for paid claims are from the State's MMIS claims system and auditable provider records. All revenues received for the Medicaid professional services will be offset against the computed cost; these revenues include payments from the State, patient copayments, and payments from other payers.

O. The Medicaid physician/practitioner amount computed in paragraph N of can be trended to current year based on CMS Market Basket update factor(s) or other medical care-related indices proposed by the State and approved by CMS. The Medicaid amount may be further adjusted to reflect increases and decreases in costs incurred resulting from changes in operations or circumstances as follows:

(1) Physician/practitioner costs not reflected on the filed Physician/practitioner cost report from which the interim costs are developed, but which would be incurred and reflected on the physician/practitioner cost report for the spending year.
(2) Physician/practitioner costs incurred and reflected on the filed physician/practitioner cost report from which the interim costs are developed, but which would not be incurred or reflected on the physician/practitioner cost report for the spending year.

Such costs must be properly documented by the hospital and subject to review by the State and CMS. The result is the Medicaid physician/practitioner amount to be used as interim Medicaid cost purposes.

4. Interim Reconciliation

The physician and non-physician practitioner interim costs determined under this Section of Exhibit A of Attachment 4.19-B which are paid for services furnished during the applicable state fiscal year are reconciled to the as-filed CMS Form 2552-96 or future version of for the same year once the cost reports have been filed with the State.

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

5. Final Reconciliation
Upon issuance of a Notice of Program Reimbursement for CMS Form 2552-96 or future version cost report(s) that incorporate the State fiscal year, each hospital's interim reconciliation will be reconciled to its CMS Form 2552-96 or future version 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.

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 Hospital Based Ambulance Services for State Government Owned and Operated Hospitals and Non State Owned or Operated Government Hospitals

This section describes the cost identification methodology related to hospital based ambulance services provided at eligible government-operated hospitals or the government entities for the uncompensated Medicaid costs of ambulance services to Medicaid eligible beneficiaries.

Eligible professional costs are reported on the designated hospitals' Medicare CMS Form 2552-96 or future version of the cost report

1. General Reimbursement Requirements

A. The government-operated hospitals meeting the definition of State owned or operated government hospital or Non State owned or operated government hospital per Attachment 4.19-B paragraphs 14a(5) and 14a(6) are eligible providers that will certify the un-reimbursed Medicaid costs specified below.

B. Eligible providers will receive payments as outlined on page 8 of Attachment 4.19-B on an interim basis.

C. Notwithstanding any other provision of this State Plan, reimbursement for the otherwise uncompensated costs of Medicaid eligible services described in this Exhibit of Attachment 4.19-B, that are provided to Medicaid eligible patients by hospital based ambulance services of government-operated hospitals (both State and Non-State) by this Exhibit of Attachment 4.19-B.

2. Reimbursement Methodology

This methodology will approximate the difference between the interim payment per Attachment 4.19-B page 8 and the allowable Medicaid costs related to the hospital based ambulance services for Federal financial participation. This computation of establishing

the interim Medicaid costs must be performed on an annual basis and in a manner consistent with the instructions below.

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. These charges must be associated with covered claims for services furnished during the period covered by the latest as-filed cost report.

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.

The amount of the Medicaid unreimbursed costs will be based on the Medicaid interim payments and costs for the period coinciding with the latest as-filed cost report; the data sources for paid claims are from the State's MMIS claims system and auditable provider records. All revenues received for the Medicaid ambulance services will be offset against the computed cost; these revenues include payments from the State, patient copayments, and payments from other payers.

H. The Medicaid ambulance services amount computed in paragraph G will be trended to current year based on CMS Market Basket update factor(s) or other medical care-related indices proposed by the State and approved by CMS.

3. Interim Reconciliation

The ambulance services interim costs determined under section of this Exhibit of Attachment 4.19-B which are paid for services furnished during the applicable state fiscal year are reconciled to the as-filed CMS Form 2552-96 or future version of for the same year once the cost reports have been filed with the State.

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

4. Final Reconciliation

Upon issuance of a Notice of Program Reimbursement for CMS Form 2552-96 or future version cost report(s) that incorporate the State fiscal year, each hospital's interim reconciliation will be reconciled to its CMS Form 2552-96 or future version 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.

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 Hospital Based Home Health Services for State Government Owned and Operated Hospitals and Non State Owned or Operated Government Hospitals

This section describes the cost identification methodology related to hospital based home health agencies provided at eligible government-operated hospitals or the government entities for the uncompensated Medicaid costs of home health services to Medicaid eligible beneficiaries. Only the otherwise uncompensated costs of home health services not claimed by the hospital as Medicaid inpatient hospital services under the hospital's provider number, or not otherwise recognized under the methodology set forth in Attachment 4.19-A and methodologies for reimbursement for government operated outpatient hospital services set forth in other sections of this Attachment 4.1 9-B, are eligible for reimbursement under this Exhibit of Attachment 4.19-B.

Eligible home health agency costs are reported on the designated hospitals' Medicare CMS Form 2552-96 or future version of the cost report

1. General Reimbursement Requirements

A. The government-operated hospitals meeting the definition of State owned or operated government hospital or Non State owned or operated government hospital per Attachment 4.19-B paragraphs 14a(5) and 14a(6) are eligible providers that will certify the un-reimbursed Medicaid costs specified below.

B. Eligible providers will receive payments as outlined in Attachment 4.19-B on interim basis.

In addition, additional expenditures will be claimed for eligible providers up to cost as specified in this section of this Exhibit. The reimbursement under this Exhibit is available only for Medicaid costs that are in excess of Medicaid interim payments.

C. Notwithstanding any other provision of this State Plan, reimbursement for the otherwise uncompensated costs of Medicaid eligible services described in this Exhibit of Attachment 4.19-B, that are provided to Medicaid eligible patients by hospital based home health agencies of government-operated hospitals (both State and Non-State) by this Exhibit of Attachment 4.19-B.

2. Reimbursement Methodology

This methodology will approximate the difference between the interim payment per Attachment 4.19-B and the allowable Medicaid costs related to the hospital based home health agencies for Federal financial participation. This computation of establishing the interim Medicaid costs must be performed on an annual basis and in a manner consistent with the instructions below.

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 health 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. These visits and charges must be associated with paid claims for services furnished during the period covered by the latest as-filed cost report.

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

(1) 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.

(2) 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.

I. 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.

The amount of the Medicaid cost will be based on the Medicaid interim payments and costs for the period coinciding with the latest as-filed cost report; the data sources for paid claims are from the State's MMIS claims system and auditable provider records. All revenues received for the Medicaid home health services

will be offset against the computed cost; these revenues include payments from the State, patient copayments, and payments from other payers.

J. The Medicaid home health services amount computed in paragraph I will be trended to current year based on CMS Market Basket update factor(s) or other medical care-related indices proposed by the State and approved by CMS.

3. Interim Reconciliation

The home health services interim costs determined under this section of Exhibit A of Attachment 4.19-B which are paid for services furnished during the applicable state fiscal year are reconciled to the as-filed CMS Form 2552-96 or future version of for the same year once the cost reports have been filed with the State.

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

4. Final Reconciliation

Upon issuance of a Notice of Program Reimbursement for CMS Form 2552-96 or future version cost report(s) that incorporate the State fiscal year, each hospital's interim reconciliation will be reconciled to its CMS Form 2552-96 or future version 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.

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 Hospital Based Hospice Services for State Government Owned and Operated Hospitals and Non State Owned or Operated Government Hospitals

This section describes the cost identification methodology related to hospital based hospice provided at eligible government-operated hospitals or the government entities for the uncompensated Medicaid costs of such services to Medicaid eligible beneficiaries. Only the otherwise uncompensated costs of hospice not claimed by the hospital as Medicaid inpatient hospital services under the hospital's provider number, or not otherwise recognized under the methodology set forth in Attachment 4.19-A and

methodologies for reimbursement for government operated outpatient hospital services set forth in other sections of this Attachment 4.1 9-B, are eligible for reimbursement under this Exhibit of Attachment 4.19-B.

Eligible hospice costs are reported on the designated hospitals' Medicare CMS Form 2552-96 or future version of the cost report

1. General Reimbursement Requirements

A. The government-operated hospitals meeting the definition of State owned or operated government hospital or Non State owned or operated government hospital per Attachment 4.19-B paragraphs 14a(5) and 14a(6) are eligible providers that will certify the un-reimbursed Medicaid costs specified below.

B. Eligible providers will receive payments as outlined in Attachment 4.19-B on interim basis.

In addition, additional expenditures will be claimed for eligible providers up to cost as specified in this section of this Exhibit. The reimbursement under this Exhibit is available only for Medicaid costs that are in excess of Medicaid interim payments.

C. Notwithstanding any other provision of this State Plan, reimbursement for the otherwise uncompensated costs of Medicaid eligible services described in this Exhibit of Attachment 4.19-B, that are provided to Medicaid eligible patients by hospital based hospice of government-operated hospitals (both State and Non-State) by this Exhibit of Attachment 4.19-B.

2. Reimbursement Methodology

This methodology will approximate the difference between the interim payment per Attachment 4.19-B and the allowable Medicaid costs related to the hospital based home health agencies for Federal financial participation. This computation of establishing the interim Medicaid costs must be performed on an annual basis and in a manner consistent with the instructions below.

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. These days must be associated with covered claims for services furnished during the period covered by the latest as-filed cost report.

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.

The amount of the Medicaid cost will be based on the Medicaid interim payments and costs for the period coinciding with the latest as-filed cost report; the data sources for paid claims are from the State's MMIS claims system and auditable provider records. All revenues received for the Medicaid hospice services will be offset against the computed cost; these revenues include payments from the State, patient copayments, and payments from other payers.

H. The Medicaid hospice services amount computed in paragraph G will be trended to current year based on CMS Market Basket update factor(s) or other medical care-related indices proposed by the State and approved by CMS.

3. Interim Reconciliation

The hospice services interim costs determined under this section of Exhibit A of Attachment 4.19-B which are paid for services furnished during the applicable state fiscal year are reconciled to the as-filed CMS Form 2552-96 or future version of for the same year once the cost reports have been filed with the State.

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

4. Final Reconciliation

Upon issuance of a Notice of Program Reimbursement for CMS Form 2552-96 or future version cost report(s) that incorporate the State fiscal year, each hospital's interim reconciliation will be reconciled to its CMS Form 2552-96 or future version 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.

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 Hospital Based Pharmacy Prescription Services for State Government Owned and Operated Hospitals and Non State Owned or Operated Government Hospitals

This section describes the cost identification methodology related to hospital based pharmacy prescription services provided at eligible government-operated hospitals or the government entities for the uncompensated Medicaid costs of such services to Medicaid eligible beneficiaries. Only the otherwise uncompensated costs of pharmacy prescription services not claimed by the hospital as Medicaid inpatient hospital services under the hospital's provider number, or not otherwise recognized under the methodology set forth in Attachment 4.19-A and methodologies for reimbursement for government operated outpatient hospital services set forth in other sections of this Attachment 4.1 9-B, are eligible for reimbursement under this Exhibit of Attachment 4.19-B.

Eligible pharmacy prescription costs are reported on the designated hospitals' Medicare CMS Form 2552-96 or future version of the cost report

1. General Reimbursement Requirements

A. The government-operated hospitals meeting the definition of State owned or operated government hospital or Non State owned or operated government hospital per Attachment 4.19-B paragraphs 14a(5) and 14a(6) are eligible providers that will certify the un-reimbursed Medicaid costs specified below.

B. Eligible providers will receive payments as outlined in Attachment 4.19-B on interim basis.

In addition, additional expenditures will be claimed for eligible providers up to cost as specified in this section of this Exhibit. The reimbursement under this Exhibit is available only for Medicaid costs that are in excess of Medicaid interim payments.

C. Notwithstanding any other provision of this State Plan, reimbursement for the otherwise uncompensated costs of Medicaid eligible services described in this Exhibit of Attachment 4.19-B, that are provided to Medicaid eligible patients by hospital based pharmacy prescription services of government-operated hospitals (both State and Non-State) by this Exhibit of Attachment 4.19-B.

2. Reimbursement Methodology

This methodology will approximate the difference between the interim payment per Attachment 4.19-B and the allowable Medicaid costs related to the hospital based pharmacy prescription services for Federal financial participation. This computation of establishing the interim Medicaid costs must be performed on an annual basis and in a manner consistent with the instructions below.

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. These charges must be associated with covered claims for services furnished during the period covered by the latest as-filed cost report. These charges are unduplicated from other services identified elsewhere in this attachment.

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.

The amount of the Medicaid cost will be based on the Medicaid interim payments and costs for the period coinciding with the latest as-filed cost report; the data sources for paid claims are from the State's MMIS claims system and auditable provider records. All revenues received for the Medicaid pharmacy prescription services will be offset against the computed cost; these revenues include payments from the State, patient copayments, and payments from other payers.

H. The Medicaid pharmacy prescription services amount computed in paragraph G will be trended to current year based on CMS Market Basket update factor(s) or other medical care-related indices proposed by the State and approved by CMS.

3. Interim Reconciliation

The pharmacy prescription services interim costs determined under this section of Exhibit A of Attachment 4.19-B which are paid for services furnished during the applicable state fiscal year are reconciled to the as-filed CMS Form 2552-96 or future version of for the same year once the cost reports have been filed with the State.

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

4. Final Reconciliation

Upon issuance of a Notice of Program Reimbursement for CMS Form 2552-96 or future version cost report(s) that incorporate the State fiscal year, each hospital's interim reconciliation will be reconciled to its CMS Form 2552-96 or future version 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.

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 Hospital Based Durable Medical Equipment for State Government Owned and Operated Hospitals and Non State Owned or Operated Government Hospitals

This section describes the cost identification methodology related to hospital based durable medical equipment provided at eligible government-operated hospitals or the government entities for the uncompensated Medicaid costs of such services to Medicaid eligible beneficiaries. Only the otherwise uncompensated costs of durable medical equipment not claimed by the hospital as Medicaid inpatient hospital services under the hospital's provider number, or not otherwise recognized under the methodology set forth in Attachment 4.19-A and methodologies for reimbursement for government operated outpatient hospital services set forth in other sections of this Attachment 4.1 9-B, are eligible for reimbursement under this Exhibit of Attachment 4.19-B.

Eligible durable medical equipment costs are reported on the designated hospitals' Medicare CMS Form 2552-96 or future version of the cost report

1. General Reimbursement Requirements

A. The government-operated hospitals meeting the definition of State owned or operated government hospital or Non State owned or operated government hospital per Attachment 4.19-B paragraphs 14a(5) and 14a(6) are eligible providers that will certify the un-reimbursed Medicaid costs specified below.

B. Eligible providers will receive payments as outlined in Attachment 4.19-B on an interim basis.

In addition, additional expenditures will be claimed for eligible providers up to cost as specified in this section of this Exhibit. The reimbursement under this Exhibit is available only for Medicaid costs that are in excess of Medicaid interim payments.

C. Notwithstanding any other provision of this State Plan, reimbursement for the otherwise uncompensated costs of Medicaid eligible services described in this Exhibit of Attachment 4.19-B, that are provided to Medicaid eligible patients by hospital based durable medical equipment of government-operated hospitals (both State and Non-State) by this Exhibit of Attachment 4.19-B.

2. Reimbursement Methodology

This methodology will approximate the difference between the interim payment per Attachment 4.19-B and the allowable Medicaid costs related to the hospital based durable medical equipment for Federal financial participation. This computation of establishing the interim Medicaid costs must be performed on an annual basis and in a manner consistent with the instructions below.

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. These charges must be associated with covered claims for services furnished during the period covered by the latest as-filed cost report.

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.

The amount of the Medicaid cost will be based on the Medicaid interim payments and costs for the period coinciding with the latest as-filed cost report; the data sources for paid claims are from the State's MMIS claims system and auditable provider records. All revenues received for the Medicaid durable medical equipment will be offset against the computed cost; these revenues include payments from the State, patient copayments, and payments from other payers.

H. The Medicaid durable medical equipment amount computed in paragraph G will be trended to current year based on CMS Market Basket update factor(s) or other medical care-related indices proposed by the State and approved by CMS.

3. Interim Reconciliation

The durable medical equipment interim costs determined under this section of Exhibit A of Attachment 4.19-B which are paid for services furnished during the applicable state fiscal year are reconciled to the as-filed CMS Form 2552-96 or future version of for the same year once the cost reports have been filed with the State.

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

4. Final Reconciliation
Upon issuance of a Notice of Program Reimbursement for CMS Form 2552-96 or future version cost report(s) that incorporate the State fiscal year, each hospital's interim reconciliation will be reconciled to its CMS Form 2552-96 or future version 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.

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 Hospital Based Outpatient Renal Dialysis Services for State Government Owned and Operated Hospitals and Non State Owned or Operated Government Hospitals

This section describes the cost identification methodology related to hospital based outpatient renal dialysis services provided at eligible government-operated hospitals or the government entities for the uncompensated Medicaid costs of such services to Medicaid eligible beneficiaries. Only the otherwise uncompensated costs of outpatient renal dialysis services not claimed by the hospital as Medicaid inpatient hospital services under the hospital's provider number, or not otherwise recognized under the methodology set forth in Attachment 4.19-A and methodologies for reimbursement for government operated outpatient hospital services set forth in other sections of this Attachment 4.1 9-B, are eligible for reimbursement under this Exhibit of Attachment 4.19-B.

Eligible outpatient renal dialysis services costs are reported on the designated hospitals' Medicare CMS Form 2552-96 or future version of the cost report

1. General Reimbursement Requirements

A. The government-operated hospitals meeting the definition of State owned or operated government hospital or Non State owned or operated government hospital per Attachment 4.19-B paragraphs 14a(5) and 14a(6) are eligible providers that will certify the un-reimbursed Medicaid costs specified below.

B. Eligible providers will receive payments as outlined in Attachment 4.19-B on an interim basis.

In addition, additional expenditures will be claimed for eligible providers up to cost as specified in this section of this Exhibit. The reimbursement under this Exhibit is available only for Medicaid costs that are in excess of Medicaid interim payments.

C. Notwithstanding any other provision of this State Plan, reimbursement for the otherwise uncompensated costs of Medicaid eligible services described in this Exhibit of Attachment 4.19-B, that are provided to Medicaid eligible patients by hospital based outpatient renal dialysis services of government-operated hospitals (both State and Non-State) by this Exhibit of Attachment 4.19-B.

2. Reimbursement Methodology

This methodology will approximate the difference between the interim payment per Attachment 4.19-B and the allowable Medicaid costs related to the hospital based outpatient renal dialysis services for Federal financial participation. This computation of establishing the interim Medicaid costs must be performed on an annual basis and in a manner consistent with the instructions below.

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. These treatments must be associated with covered claims for services furnished during the period covered by the latest as-filed cost report.

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.

The amount of the Medicaid cost will be based on the Medicaid interim payments and costs for the period coinciding with the latest as-filed cost report; the data sources for paid claims are from the State's MMIS claims system and auditable provider records. All revenues received for the Medicaid outpatient renal dialysis services will be offset against the computed cost; these revenues include payments from the State, patient copayments, and payments from other payers.

H. The Medicaid outpatient renal dialysis services amount computed in paragraph G will be trended to current year based on CMS Market Basket update factor(s) or other medical care-related indices proposed by the State and approved by CMS.

3. Interim Reconciliation

The outpatient renal dialysis services interim costs determined under this section of Exhibit A of Attachment 4.19-B which are paid for services furnished during the applicable state fiscal year are reconciled to the as-filed CMS Form 2552-96 or future version of for the same year once the cost reports have been filed with the State.

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

4. Final Reconciliation

Upon issuance of a Notice of Program Reimbursement for CMS Form 2552-96 or future version cost report(s) that incorporate the State fiscal year, each hospital's interim reconciliation will be reconciled to its CMS Form 2552-96 or future version 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.

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 Hospital Based Rural Health Center/Federal Qualified Health Center for State Government Owned and Operated Hospitals and Non State Owned or Operated Government Hospitals

This section describes the cost identification methodology related to hospital based rural health center/federal qualified health center provided at eligible government-operated hospitals or the government entities for the uncompensated Medicaid costs of such services to Medicaid eligible beneficiaries. Only the otherwise uncompensated costs of rural health center/federal qualified health center not claimed by the hospital as Medicaid inpatient hospital services under the hospital's provider number, or not otherwise recognized under the methodology set forth in Attachment 4.19-A and methodologies for reimbursement for government operated outpatient hospital services set forth in other sections of this Attachment 4.1 9-B, are eligible for reimbursement under this Exhibit of Attachment 4.19-B.

Eligible rural health center/federal qualified health center costs are reported on the designated hospitals' Medicare CMS Form 2552-96 or future version of the cost report

1. General Reimbursement Requirements

A. The government-operated hospitals meeting the definition of State owned or operated government hospital or Non State owned or operated government hospital per

Attachment 4.19-B paragraphs 14a(5) and 14a(6) are eligible providers that will certify the un-reimbursed Medicaid costs specified below.

B. Eligible providers will receive payments as outlined in Attachment 4.19-B on interim basis.

In addition, additional expenditures will be claimed for eligible providers up to cost as specified in this section of this Exhibit. The reimbursement under this Exhibit is available only for Medicaid costs that are in excess of Medicaid interim payments.

C. Notwithstanding any other provision of this State Plan, reimbursement for the otherwise uncompensated costs of Medicaid eligible services described in this Exhibit of Attachment 4.19-B, that are provided to Medicaid eligible patients by hospital based rural health center/federal qualified health center of government-operated hospitals (both State and Non-State) by this Exhibit of Attachment 4.19-B.

2. Reimbursement Methodology

This methodology will approximate the difference between the interim payment per Attachment 4.19-B and the allowable Medicaid costs related to the hospital based rural health center/federal qualified health center for Federal financial participation. This computation of establishing the interim Medicaid costs must be performed on an annual basis and in a manner consistent with the instructions below.

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:

   (1) Worksheet M-3 Part I Line 3 Column 1 for allowable cost excluding vaccines

   (2) Worksheet M-4 Part I Line 10 Column 1 for cost of pneumococcal vaccine injections

   (3) 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:

(1) Worksheet M-3 Part I Line 6 Column 1 for total adjusted clinic visits

(2) Worksheet M-4 Part I Line 11 Column 1 for total number of pneumococcal vaccine injections

(3) 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. These visits and vaccines must be associated with covered claims for services furnished during the period covered by the latest as-filed cost report.

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.

The amount of the Medicaid cost will be based on the Medicaid interim payments and costs for the period coinciding with the latest as-filed cost report; the data sources for paid claims are from the State's MMIS claims system and auditable provider records. All revenues received for the Medicaid rural health center/federal qualified health center will be offset against the computed cost; these revenues include payments from the State, patient copayments, and payments from other payers.

H. The Medicaid rural health center/federal qualified health center amount computed in paragraph G will be trended to current year based on CMS Market Basket

update factor(s) or other medical care-related indices proposed by the State and approved by CMS.

3. Interim Reconciliation

The rural health center/federal qualified health center interim costs determined under this section of Exhibit A of Attachment 4.19-B which are paid for services furnished during the applicable state fiscal year are reconciled to the as-filed CMS Form 2552-96 or future version of for the same year once the cost reports have been filed with the State.

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

4. Final Reconciliation

Upon issuance of a Notice of Program Reimbursement for CMS Form 2552-96 or future version cost report(s) that incorporate the State fiscal year, each hospital's interim reconciliation will be reconciled to its CMS Form 2552-96 or future version 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.

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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF ALABAMA

DEFINITION OF A CLAIM

Effective Date: 10/01/80

Within the guidelines of 42 CFR 447.45(b), the definition of a claim for each of the several types of covered services provided recipients through the Alabama Medicaid Program is included in this attachment. In each of the definitions the term "claim form" is used. This does not limit the submission of claims to hardcopy. Submission of claims in any Medicaid prior approved method is acceptable. This could include magnetic tape, diskettes, or continuous form of billing.

Effective Date: 10/01/09

1. Inpatient Hospital Claim

An inpatient Hospital Claim is a bill for all services provided a recipient by a provider and submitted for payment on an approved Medicaid claim for each in-hospital period in a calendar year. Except for children under the age of one, or under the age of six who are receiving medically necessary inpatient services in a hospital which has been designated by Medicaid as a disproportionate share hospital, or additional inpatient days that have been authorized for deliveries, or children who have been referred for treatment as the result of an EPSDT screening, the first 16 days in a calendar year will be reimbursed based on an established per diem rate. Subsequent days will be factored into the establishment of cost as described in Attachment 4.19-A of this State Plan.

Effective Date: 10/01/09

2. Outpatient Hospital Claim

An Outpatient Hospital Claim is a bill for all services except physician charges provided a recipient by a provider and submitted for payment on an approved Medicaid claim for each visit, except for chemotherapy, physical or occupational, and radiation therapy which may be span billed for services rendered during a calendar year.

Effective Date: 07/01/87

3. Rural Health Clinic Claim

A Rural Health Clinic Claim is a bill for all services provided a recipient by a provider and submitted for payment on an approved Medicaid claim form for each encounter.

Effective Date: 07/01/87

4. Renal Dialysis Center Claim

A Renal Dialysis Center Claim is a bill for all services provided a recipient by a provider and submitted for payment on an approved Medicaid claim form. A claim may be for each visit or span billed for services provided during a calendar month.

Effective Date: 10/01/83

5. Physicians Claim

A Physician Claim is a bill for all services identified by procedure codes provided to a recipient over a period of time by a provider and submitted for payment on an approved Medicaid claim form.

6. Laboratory Claim

A Laboratory Claim is a bill for all services provided a recipient over a period of time by a provider and submitted for payment on an approved Medicaid claim form.

7. X-ray Services Claim

An X-ray Services Claim is a bill for all services provided a recipient over a period of time by a provider and submitted for payment on an approved Medicaid claim form.

Effective Date: 10/01/83

8. Home Health, Family Planning, Prenatal, Hearing Aid, EPSDT Claim

A claim for each of these covered services will be a bill for all services provided a recipient by a provider and submitted for payment on an approved Medicaid claim form.

Effective Date: 10/01/83

9. Durable Medical Equipment/Supplier Claim

A Durable Medical Equipment/Supplier Claim is a bill for item(s) by a procedure code, provided a recipient for one date or over a period of time by a provider and submitted for payment on an approved Medicaid claim form.

10. Optometric Claim

An Optometric Claim is a bill for services by a provider over a period of time for all procedures provided a recipient and submitted on an approved claim form.

11. Ambulance Service Claim

An Ambulance Service Claim is a bill for all services provided to a recipient for one date of ambulance service by a provider and submitted for payment on an approved Medicaid claim form.

Effective Date: 10/01/83

12. Pharmacy Claim

A pharmacy Claim is a bill for one prescription filled for a recipient by a pharmacy provider and submitted on an approved Medicaid Pharmacy Claim Form or any Medicaid Claim form.

A medical claim which contains one or more injectable drug line items is deemed to be one drug claim, for administrative reimbursement purposes only.

Effective Date: 10/01/83

13. Dental Claim (EPSDT)

An EPSDT related dental claim is a bill for all services identified by procedure code provided to a recipient over a period of time by a provider and submitted for payment on an approved Medicaid claim form.

14. Group Claim

A Group Claim is a claim for long term care services which lists each recipient as a line item for a period of service by a provider and is submitted for payment on an approved Medicaid claim form.

15. Medicare Crossover Claim

A Medicare Crossover Claim is a bill for services provided a recipient by a provider and submitted on an approved federal form containing an Alabama Medicaid Recipient Number, together with a copy of the explanation of Medicare benefits paid, with a copy of the explanation of Medicare benefits paid, including deductible and coinsurance paid. (With prior approval of Medicaid, the submission may be by tape-to-tape transfer.)