Table of Contents

State/Territory Name: Alabama

State Plan Amendment (SPA) #:11-016

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

MAY 09 2013

Ms. Stephanie McGee Azar
Acting Commissioner
Alabama Medicaid Agency
P.O. Box 5624
501 Dexter Avenue
Montgomery, Alabama 36103

Re: Alabama State Plan Amendment 11-016

Dear Ms. Azar:

We have reviewed the proposed amendment to Attachment 4.19-A and 4.19-B of your Medicaid State plan submitted under transmittal number (TN) 11-016. Effective October 1, 2011 this amendment proposes to revise the state plan to reimburse for inpatient and outpatient hospital services. Specifically, the state will continue to use the certified public expenditures (CPE) as the non-federal share of payments for governmental providers and reimburse private providers on a per diem basis for inpatient services and cost to charge basis for outpatient services with supplemental "access" payments that will not exceed the upper payment limit. Also the amendment updates the base year cost reports to 2009 to calculate the upper payment limit.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(13), 1902(a)(30), and 1903(a) of the Social Security Act and the implementing Federal regulations at 42 CFR Part 447. We have found that the proposed reimbursement methodology complies with applicable requirements and therefore have approved them with an effective date of October 1, 2011. We are enclosing the CMS-179 and the amended approved plan pages.

If you have any questions, please call Dicky Sanford at (334) 241-0044.

Sincerely

//s//

Cindy Mann
Director

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: AL-11-016

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, 2011

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 12 $236,120,163
b. FFY 13 $236,120,163

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A, pages 3A, 6H-6J, 8D-8E, 14, 20-23
Attachment 4.19B, pages 8, 8.1- 8.3
Attachment 3.1-A, page 1
4.19-A, Exhibit C
4.19-B, Exhibit A
4.19-E, page 1

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

AL-05-009

10. SUBJECT OF AMENDMENT:
The primary purpose for this amendment is to extend the private hospital assessment and Medicaid funding program for FY 2012 and 2013; to change the base year to fiscal year 2009 for purposes of calculating assessment; to change the assessment rate for fiscal years 2012 and 2013; and to change the methodology for base payments for OP hospital services for state fiscal years 2012 and 2013.

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:
R. Bob Mullins, Jr., MD

14. TITLE: Commissioner

15. DATE SUBMITTED:

16. RETURN TO:
R. Bob Mullins, Jr., MD
Commissioner
Alabama Medicaid Agency
501 Dexter Avenue
Post Office Box 5624
Montgomery, Alabama 36103-5624

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 08-31-11

18. DATE APPROVED: 05/09/13

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 10/01/11

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

21. TYPED NAME:
Cindy Mann

22. TITLE: Director

23. REMARKS:

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 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 cost report(s) that incorporate the State fiscal year, each hospital's interim reconciliation will be reconciled to its CMS Form 2552 cost report as adjusted by the MAC 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.

Hospice costs are reported on the designated hospitals' Medicare CMS Form 2552 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 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 cost report Worksheet K-6 Lines 1 Column 4.

B. The hospice cost related to graduate medical education activities is as follows:

CMS Form 2552-96	*CMS Form 2552-10*
Worksheet B Part I Lines 93, Column 22 and 23.	Worksheet B Part I Lines 116, Column 21 and 22.

C. Total billed hospice unduplicated days are identified from each hospital's most recently filed CMS Form 2552 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 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 cost report(s) that incorporate the State fiscal year, each hospital's interim reconciliation will be reconciled to its CMS Form 2552 cost report as adjusted by the MAC 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 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 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 cost report as follows:

CMS Form 2552-96: Worksheet C Part I, Line 56, Column 1
CMS Form 2552-10: Worksheet C Part I, Line 73, Column 1

Prescription pharmacy may have been moved from CMS lines stated above by adjustments made by hospital or Medicare fiscal intermediary. If cost is reported on separate CMS line than the CMS line reported on the applicable CMS Form 2552 should be used from Worksheet C or Worksheet B Part I Column 27 for the CMS Form 2552-96 and Worksheet B Part I Column 26 per CMS Form 2552-10 if CMS line is not reported on Worksheet C.

B. The pharmacy cost related to graduate medical education activities is as follows:

CMS Form 2552-96: Worksheet B Part I, Line 56, Column 22 and 23
CMS Form 2552-10: Worksheet B Part I, Line 73, Column 21 and 22

Prescription pharmacy may have been moved from CMS lines stated above by adjustments made by hospital or Medicare fiscal intermediary. If cost is reported on separate CMS line, then the CMS line reported on the applicable CMS Form 2552 should be used for graduate medical education reported on Worksheet B Part I, Column 22 and 23 for CMS Form 2552-96 and Worksheet B Part I Columns 21 and 22 for CMS Form 2552-10.

C. Total billed pharmacy charges are identified from each hospital's most recently filed CMS Form 2552 cost report as follows:

CMS Form 2552-96: Worksheet C Part I, Line 56, Column 8
CMS Form 2552-10: Worksheet C Part I, Line 73, Column 8

Prescription pharmacy may have been moved from CMS lines stated above by adjustments made by hospital or Medicare fiscal intermediary. If the cost has been reported on a different CMS line, then the CMS line reported on the applicable CMS Form 2552, Worksheet C, Column 8 or prescription pharmacy charges from hospital's financial records should be used to determine total charges.

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 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 cost report(s) that incorporate the State fiscal year, each hospital's interim reconciliation will be reconciled to its CMS Form 2552 cost report as adjusted by the MAC 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 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 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 cost report as follows:

CMS Form 2552-96: Worksheet C Part I, Lines 66 and 67, Column 1
CMS Form 2552-10: Worksheet C Part I, Line 96 and 97, Column 1

B. The durable medical equipment cost related to graduate medical education activities is as follows:

CMS Form 2552-96: Worksheet B Part I, Lines 66 and 67, Column 22 and 23
CMS Form 2552-10: Worksheet B Part I, Line 96 and 97, Column 21 and 22

C. Total billed durable medical equipment charges are identified from each hospital's most recently filed CMS Form 2552 cost report as follows:

CMS Form 2552-96: Worksheet C Part I, Lines 66 and 67, Column 8
CMS Form 2552-10: Worksheet C Part I, Line 96 and 97, 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 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 cost report(s) that incorporate the State fiscal year, each hospital's interim reconciliation will be reconciled to its CMS Form 2552 cost report as adjusted by the MAC 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 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 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 cost report as follows:

CMS Form 2552-96	*CMS Form 2552-10*
Worksheet I-4 Lines 1-10, Column 2.	Worksheet I-4 Lines 1-10, Column 2.

B. The outpatient renal dialysis services cost related to graduate medical education activities as follows:

CMS Form 2552-96	*CMS Form 2552-10*
Worksheet B Part I Line 57 and Line 64, Column 22 and 23. Cost will be allocated based on total cost on Worksheet I-4 Lines 1-10.	Worksheet B Part I Line 74, Column 21 and 22. Cost will be allocated based on total cost on Worksheet I-4 Lines 1-10.

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 cost report as follows:

CMS Form 2552-96	*CMS Form 2552-10*
Worksheet I-4 Lines 1-10, Column 2.	Worksheet I-4 Lines 1-10, Column 2.

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 number of 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 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 cost report(s) that incorporate the State fiscal year, each hospital's interim reconciliation will be reconciled to its CMS Form 2552 cost report as adjusted by the MAC 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 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 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 cost report as follows:

CMS Form 2552-96	*CMS Form 2552-10*
Worksheet M-3 Line 3 Column 1 for allowable cost excluding vaccines.	Worksheet M-3 Line 3 Column 1 for allowable cost excluding vaccines.
Worksheet M-4 Line 10, Column 1 for cost of pneumococcal vaccine injections	Worksheet M-4 Line 10, Column 1 for cost of pneumococcal vaccine injections
Worksheet M-4 Line 10, Column 2 for cost of influenza vaccine injections	Worksheet M-4 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 as follows:

CMS Form 2552-96	*CMS Form 2552-10*
Worksheet B Part I Line 63.50, Column 22 and 23.	Worksheet B Part I Lines 88 and/or 89, Column 21 and 22.

C. Total billed rural health center/federal qualified health center visits/vaccines are identified from each hospital's most recently filed CMS Form 2552 cost report as follows:

CMS Form 2552-96	*CMS Form 2552-10*
Worksheet M-3 Part I Line 6 Column 1 for total adjusted clinic visits	Worksheet M-3 Part I Line 6 Column 1 for total adjusted clinic visits
Worksheet M-4 Part I Line 11 Column 1 for total number of pneumococcal vaccine injections	Worksheet M-4 Part I Line 11 Column 1 for total number of pneumococcal vaccine injections
Worksheet M-4 Part 1 Line 11 Column 2 for total number of influenza vaccine injections	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 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 cost report(s) that incorporate the State fiscal year, each hospital's interim reconciliation will be reconciled to its CMS Form 2552 cost report as adjusted by the MAC 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

METHOD FOR PAYMENT OF REASONABLE COSTS INPATIENT HOSPITAL SERVICES

Effective Date: 10/01/11

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 rates paid to out-of-state hospitals in FY 2009 inflated annually by the Global Insight.

Effective Date: 10/01/11

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 Medicare 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.

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: 10/01/2011

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. Except as otherwise noted in the plan, payment for ambulance services is based on state-developed fee schedule rates, which are the same for both governmental and private providers. The agency's rates were set as of May 14, 2010 and are effective for services provided on or after that date. The fee schedule is subject to annual/periodic adjustments and all current rates are published and maintained on the Alabama Medicaid Agency's website as follows:
http://www.medicaid.alabama.gov/documents/6.0_Providers/6.6_Fee_Schedules/6.6_Ambulance_Rates_12-21-11.pdf

12. Nurse-midwives

Effective Date: 10/01/2011

Payment to nurse-midwives shall be based on payments made to physicians for similar services. Payment to midwives shall be 80% of the amount paid to physicians. Except as otherwise noted in the plan, payment for nurse-midwife services is based on 80% of the state-developed physician fee schedule rates, which are the same for both governmental and private providers. The agency's rates were set as of January 15, 1992 and are effective for services provided on or after that date. The fee schedule is subject to annual/periodic adjustments and all current rates are published and maintained on the Alabama Medicaid Agency's website as follows:
http://www.medicaid.alabama.gov/documents/6.0_Providers/6.6_Fee_Schedules/6.6_Physician_Fee_Sched_8-12-11.pdf

13. Outpatient Hospital Services
Effective Date: 10/01/2011

a. Definitions Related to Payments for Outpatient Hospital Services

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

(2) Hospital: For purposes of Medicaid base fee schedule payments, access payments, enhancement payments, quarterly adjustment and DSH payments for the period from October 1, 2011, through September 30, 2013, 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 Form 2552-96 or CMS Form 2552-10 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).

(4) Privately Owned or Operated Hospital: For purposes of Medicaid base, access and DSH payments for the period from October 1, 2011, through September 30, 2013, 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 fee schedule payments, quarterly adjustment and DSH payments for the period from October 1, 2011, through September 30, 2013, 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 fee schedules, quarterly adjustment and DSH payments for the period from October 1, 2011, through September 30, 2013, 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.

For State fiscal years 2012 and 2013, Medicaid shall pay each in-state hospital a base amount from approved rates based on procedure codes. The Agency's outpatient rates will be set using the fee schedule adopted by the Agency as of October 1, 2009, with a six percent (6%) inflation rate applied for each procedure code.

Payment for all out-of-state outpatient hospital services will be from approved rates based on procedure codes. 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 as follows:
http://www.medicaid.alabama.gov/CONTENT/6.0_Providers/6.6_Fee_Schedules.aspx

In addition to base payments, quarterly cost adjustment payments will be made for State Owned or Operated Hospitals and Non State Owned or Operated Government Hospitals. These quarterly cost adjustment payments will be included as interim payments in the calculation of certified public expenditures as outlined in Attachment 4.19-B Exhibit A.

c. Upper Payment Limit

For the period from October 1, 2011, through September 30, 2013, 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) Privately owned and operated hospitals cost reports a fiscal year ending during the calendar year 2009 were used in the calculation of the estimate.
(2) From the CMS Form 2552-96 cost reporting forms, a total cost to charges ratio was calculated as follows:
   a. Total cost will equal Worksheet B Part I Line 95 Column 25 less the amounts reported on Worksheet B Part I Lines 34-36, 63.50, 65, and 71-93 Column 25 plus the reversal of Worksheet A-6 reclassifications and Worksheet A-8 adjustments related to Certified Nurse Anesthetists.
   b. Total charges will equal Worksheet C Part I Line 101 Column 8 less the amounts reported on Worksheet C Part I Lines 34-36, 63.50 and 65 Column 8 plus any CRNA revenue from hospital financial records the was originally removed from the CMS 2552-96.
   c. The total cost to charge ratio for a hospital equals the sum of costs detailed in paragraph (a) divided by the sum of charges in paragraph (b).
(3) Total Medicaid outpatient charges were obtained from the Alabama Medicaid MMIS system for claims incurred for services for each hospitals cost reporting period that ended during the calendar year 2009 which meet the definition of a paid claim for SFY 2012 and SFY 2013.
(4) Total Medicaid outpatient charges in Step (3) are multiplied by the cost to charge ratio calculated in Step (2) to determine Medicare cost of Medicaid services for each hospital's calendar year. The Medicaid cost will be increased by the Medicaid outpatient percentage of CRNA cost removed on Worksheet A-8. The Medicaid outpatient percentage is determined by dividing total Medicaid outpatient charges by total charges for the hospital. For cost reports ending during calendar year 2009, the amount will be multiplied by the product of the CMS Market Basket for Medicare outpatient prospective payment system (3.60%) and a utilization increase based on change in paid ICN claim counts from SFY 2008 to SFY 2009 for outpatient hospitals in Alabama (10.16%).

This product will be multiplied by the number of months each hospital's cost report period mid-point to the end of the State Fiscal Year 2009:

Cost Report Ended	CR Adjustment Rate
January 31, 2009	1.1667
February 28, 2009	1.0833
March 31, 2009	1.0000
April 30, 2009	0.9167
June 30, 2009	0.7500
July 31, 2009	0.5833
September 30, 2009	0.5000
December 31, 2009	0.2500

(5) To determine the estimated total Medicare cost for Medicaid Services for State Fiscal Year 2012 and State Fiscal Year 2013, the SFY 2009 Medicare cost for Medicaid services determined in Step (4) will be multiplied by the product of an increase in cost due to the CMS Market basket Outpatient Hospital PPS (http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/Downloads/mktbskt-actual.pdf) and a utilization increase using actual increases in ICN claim counts for SFYs 2010 and 2011 with a linear regression being completed for SFY 2012 and SFY 2013 using actual increases for SFY 2008 through SFY 2011. These increases are as follows:

State Fiscal Year (SFY)	SFY Factor	OPPS Market Basket	Utilization Increase	Overall Increase Factor
2010	0.50	2.10%	2.96%	1.0255
2011	1.00	2.60%	2.48%	1.0514
2012	1.00	3.00%	4.47%	1.0760
2013	1.00	2.70%	4.03%	1.0684

(6) The Medicaid allowed amount for claims included in Step (3) was obtained from the MMIS to constitute the Medicaid payments for cost reporting periods ending in calendar year 2009. The utilization increase identified in Step (4) and the cost report factors in Step (4) was applied to the Medicaid allowed amount to standardize all hospital payments to SFY 2009. The Medicaid payments for SFY 2009 were multiplied by the utilization increase amount in Step (5) to determine the Medicaid payments for SFY 2012 and SFY 2013.

(7) The difference between Medicare cost of Medicaid services determined in Step (5) and the Medicaid payments in Step (6) will be the Upper Payment Limit set forth in 42 CFT 447.321.

(8) 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 as determined in Step (5) above and base payments for the current fiscal year.

(9) Outpatient hospital access payments to privately owned and operated hospitals shall be made on a quarterly basis.

(10) Privately owned acute care hospitals, that meet the criteria in (a) and (b) below, shall be paid an enhanced payment:

a. the hospital must be located in a county with a population greater than 200,000 (according to the latest U.S. census), and
b. 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 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.

(11) The amount paid under Step (8) and Step (10) shall not exceed the amount calculated as the Upper Payment Limit in Step (7).

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** cost report, which was prepared based on Medicare cost reporting principles, as the basis for ensuring proper cost allocation and apportionment for services provided to Medicaid eligible beneficiaries and individuals with no source of third party insurance. Worksheets from the CMS Form 2552 cost report will be identified as appropriate in this Exhibit to ensure proper calculation of cost to be certified as public expenditures (CPE) for both inpatient and outpatient services, as defined in Attachment 3.1A, by hospitals. The Agency will use the protocol below.

Cost of Medicaid

1. Interim estimate of Interim Medicaid Certified Public Expenditures: Prior to the beginning of each State fiscal year, the Alabama Medicaid Agency will determine an estimate of the inpatient Medicaid CPE as follows:

    a. State government owned and operated hospitals and non-State government owned and operated cost reports with a fiscal year ending during the calendar year 2009 were used in the calculation of the estimate.

    b. From the CMS form 2552-96 cost reporting forms, a total cost to charges ratio was calculated as follows:

        i. Total cost will equal Worksheet B Part I Line 95 Column 25 less the amounts reported on Worksheet B Part I Lines 34-36, 63.50, 65, and 71-93 Column 25.
        ii. Total charges will equal Worksheet C Part I Line 101 Column 8 less the amounts reported on Worksheet C Part I Lines 34-36, 62, 63.50, and 65 Column I.

    c. Total Medicaid inpatient charges were obtained from the Alabama Medicaid MMIS system for claims incurred for services for each hospitals cost reporting period that ended during the calendar year 2009 which meet the definition of a paid claim for SFY 2012 and SFY 2013.

    d. Total Medicaid inpatient charges in paragraph c) are multiplied by the cost to charge ratio calculated in paragraph b) to determine Medicaid cost for each hospital's calendar year.

    e. The CRNA expense removed from the cost report on Worksheet A-8 will be multiplied based on the Medicaid inpatient charges divided by total charges to determine the amount included for Medicaid inpatient cost. The CRNA portion of cost related to Medicaid inpatient cost will be added to the amount in paragraph d) to report the amount of Medicaid inpatient cost for cost report year 2009.

f. For cost reports ending during calendar year 2009, the amount will be multiplied by the product of the CMS Market Basket for Medicare inpatient prospective payment system (3.60%) and a utilization increase based on change in paid days from SFY 2008 to SFY 2009 for inpatient hospitals in Alabama (3.39%). This product will be multiplied by the number of months each hospital's cost report period mid-point to the end of the State Fiscal Year 2009:

Cost Report Ended	CR Adjustment Rate
January 31, 2009	1.1667
February 28, 2009	1.0833
March 31, 2009	1.0000
April 30, 2009	0.9167
June 30, 2009	0.7500
July 31, 2009	0.5833
September 30, 2009	0.5000
December 31, 2009	0.2500

g. To determine the estimated total Medicaid cost for State Fiscal Year 2012 and State Fiscal Year 2013, the SFY 2009 Medicaid cost determined in paragraph d will be multiplied by the product of an increase in cost due to the CMS Market basket Inpatient Hospital PPS (http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/Downloads/mktbskt-actual.pdf) and a utilization increase using actual increases in paid days for SFYs 2010 and 2011 with a linear regression being completed for SFY 2012 and SFY 2013 using actual increases for SFY 2008 through SFY 2011. These increases are as follows:

State Fiscal Year (SFY)	SFY Factor	OPPS Market Basket	Utilization Increase	Overall Increase Factor
2010	0.50	2.10%	2.96%	1.0255
2011	1.00	2.60%	2.48%	1.0514
2012	1.00	3.00%	4.47%	1.0760
2013	1.00	2.70%	4.03%	1.0684

h. The Medicaid allowed amount for claims included in paragraph c was obtained from the MMIS to constitute the Medicaid payments for cost reporting periods ending in calendar year 2009. The utilization increase identified in paragraph d and the cost report factors in paragraph d was applied to the Medicaid allowed amount to standardize all hospital payments to SFY 2009. The Medicaid payments for SFY 2009 were multiplied by the utilization increase amount in paragraph e to determine the Medicaid payments for SFY 2012 and SFY 2013.

i. The difference between Medicaid cost determined in paragraph e and the Medicaid payments in paragraph f will be the amount claimed as an estimated CPE expenditure for SFY 2012 and 2013.

2. 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 estimated certified public expenditures will be reconciled to its CMS Form 2552 cost report as filed to the Medicare Administrative Contractor (MAC) 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.

This interim reconciliation will be completed within 10 months of the filing of the last electronic CMS cost report filed by a State government owned or operated or a non-State government owned or operated hospital to its applicable MAC that included the September 30th fiscal year end of the State.

The interim Medicaid inpatient hospital cost will be calculated using a cost to charge ratio calculated for each hospital using the methodology outlined in paragraph 1b on Attachment 4-19.A Page 20 (Exhibit C Page 1) for cost reports which were reported on CMS Form 2552-96. For cost reports submitted on CMS Form 2552-10, the following methodology will be used to calculate the cost to charge ratio:

1. Total Cost Determination
   a. Worksheet B Part I Line 118 Column 24
   b. Remove Worksheet B Part I Lines 44-46, 88, 95, and 101-116 Column 24
2. Total Charges Determination
   a. Worksheet C Part I Line 200 Column 8
   b. Remove Worksheet C Part I Lines 44-46, 88, 92, 95, and 101-116 Column 8

The cost to charge ratio calculated for each hospital's cost report that overlaps the applicable State Fiscal Year will be used to multiply the Medicaid charges obtained from the MMIS system that relate to that cost reporting period. Total Medicaid inpatient cost therefore will be the product of the paid claims charges from MMIS and the applicable cost to charge ratio plus the Medicaid portion of CRNA expense removed on Worksheet A-8 based on the Medicaid inpatient utilization of Medicaid inpatient charges divided by total charges. 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 sum of the estimated Medicaid CPE calculated in paragraph 1 above and the interim payments made based on paragraph (j)(3) on page 6H of Attachment 4.19-A 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.

3. Final Reconciliation of Interim Medicaid Inpatient Hospital Payment Rate Post Reporting Year: Upon issuance of a Notice of Program Reimbursement for CMS Form 2552 cost report(s) that incorporate the State fiscal year, each hospital's interim reconciliation will be reconciled to its CMS Form 2552 cost report as adjusted by the MAC 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.

This final reconciliation will be completed by the end of the third CMS Form 64 quarter that follows the CMS Form 64 quarter where the of the filing of the last electronic CMS cost report filed by a State government owned or operated or a non-State government owned or operated hospital to its applicable MAC that included the September 30th fiscal year end of the State occurs.

The final Medicaid inpatient hospital cost report will be calculated using the applicable CMS form 2552 cost report as follows:

CMS Form 2552-96	*CMS Form 2552-10*
Adjustments Made to Cost Report Prior to Calculation of Cost	Adjustments Made to Cost Report Prior to Calculation of Cost
Graduate Medical Education reported on Worksheet B Part I Columns 22 and 23 lines 25-31, 33, and 37-94 shall be included in the calculation of Medicaid cost.	Graduate Medical Education reported on Worksheet B Part I Columns 21 and 22 lines 30-43, and 50-117 shall be included in the calculation of Medicaid cost.
Medicaid Routine Service Cost for Acute Services	Medicaid Routine Service Cost for Acute Services
Cost Per Diems per Medicaid Worksheet D-1 Part II Lines 38 and 42-47 (as adjusted above) to routine days based on mapping of MMIS paid routine days to Worksheet S-3, Part I Column 5, lines 6-12.	Cost Per Diems per Medicaid Worksheet D-1 Part II Lines 38 and 42-47 (as adjusted above) to routine days based on mapping of MMIS paid routine days to Worksheet S-3, Part I Column 7, lines 7-13
Medicaid Routine Service Cost for Sub-Provider Services	Medicaid Routine Service Cost for Sub-Provider Services
Cost Per Diems per Medicaid Worksheet D-1 Part II Lines 38 (as adjusted above) on the respective Worksheet for the sub-provider times its respective days based on MMIS paid days to the applicable Worksheet S-3, Part I Column 5, line 14.	Cost Per Diems per Medicaid Worksheet D-1 Part II Lines 38 (as adjusted above) on the respective Worksheet for the sub-provider times its respective days based on MMIS paid days to the applicable Worksheet S-3, Part I Column 7, line 16-18.
Medicaid Inpatient Ancillary Cost for Acute and Sub-Provider Services	Medicaid Inpatient Ancillary Cost for Acute and Sub-Provider Services
Cost to Charge Ratios per Medicaid Worksheet D-4 (as adjusted above) for acute services and the respective sub-providers Column 1, lines 37-68 times the charges based on MMIS paid charges mapped to respective Medicaid Worksheet D-4 Column 2, Lines 37-68.	Cost to Charge Ratios per Medicaid Worksheet D-3 (as adjusted above) for acute services and the respective sub-providers Column 1, lines 50-98 times the charges based on MMIS paid charges mapped to respective Medicaid Worksheet D-3 Column 2, Lines 50-98.

Total Medicaid inpatient cost therefore will be the sum of routine service cost and ancillary service cost plus the Medicaid portion of CRNA expense removed on Worksheet A-8 based on the Medicaid inpatient utilization based on Medicaid inpatient charges divided by total charges. 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

4. 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 cost report for the fiscal year ending during the fiscal year data being used (ex. 2010 data for 2012 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 as follows:

CMS Form 2552-96	***CMS Form 2552-10***
Worksheet C Part I Column 1 line 103 less lines 34-36 (Total Cost)	Worksheet C Part I Column 1 line 202 less lines 44-46 (Total Cost)
Worksheet C Part I Column 6 line 103 less lines 34-36 (Inpatient Charges)	Worksheet C Part I Column 6 line 202 less lines 44-46 (Inpatient Charges)
Worksheet C Part I Column 7 line 103 less line 34-36 (Outpatient Charges)	Worksheet C Part I Column 7 line 202 less lines 44-46 (Outpatient Charges)
Worksheet C Part I Column 8 line 103 less line 34-36 (Total Charges)	Worksheet C Part I Column 8 line 202 less line 44-46 (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.

5. 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 cost report as filed to the MAC 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.

This interim reconciliation will be completed within 10 months of the filing of the last electronic CMS cost report filed by a State government owned or operated or a non-State government owned or operated hospital to its applicable MAC that included the September 30th fiscal year end of the State.

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 (referred to as Non-Alabama Medicaid Fee for Service (FFS) Medicaid eligible activity).

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

a. The cost of services for inpatient routine care services, inpatient ancillary services, and outpatient ancillary services will be determined as follows:

CMS Form 2552-96	*CMS Form 2552-10*
Adjustments Made to Cost Report Prior to Calculation of Cost	Adjustments Made to Cost Report Prior to Calculation of Cost
Graduate Medical Education reported on Worksheet B Part I Columns 22 and 23 lines 25-31, 33, and 37-94 shall be included in the calculation of Medicaid cost.	Graduate Medical Education reported on Worksheet B Part I Columns 21 and 22 lines 30-43, and 50-117 shall be included in the calculation of Medicaid cost.
Medicaid Routine Service Cost for Acute Services	Medicaid Routine Service Cost for Acute Services
Cost Per Diems per Medicaid Worksheet D-1 Part II Lines 38 and 42-47 (as adjusted above) to routine days based on mapping of MMIS paid routine days to Worksheet S-3, Part I Column 5, lines 6-12.	Cost Per Diems per Medicaid Worksheet D-1 Part II Lines 38 and 42-47 (as adjusted above) to routine days based on mapping of MMIS paid routine days to Worksheet S-3, Part I Column 7, lines 7-13
Medicaid Routine Service Cost for Sub-Provider Services	Medicaid Routine Service Cost for Sub-Provider Services
Cost Per Diems per Medicaid Worksheet D-1 Part II Lines 38 (as adjusted above) on the respective Worksheet for the sub-provider times its respective days based on MMIS paid days to the applicable Worksheet S-3, Part I Column 5, line 14.	Cost Per Diems per Medicaid Worksheet D-1 Part II Lines 38 (as adjusted above) on the respective Worksheet for the sub-provider times its respective days based on MMIS paid days to the applicable Worksheet S-3, Part I Column 7, line 16-18.
Medicaid Inpatient Ancillary Cost for Acute and Sub-Provider Services	Medicaid Inpatient Ancillary Cost for Acute and Sub-Provider Services
Cost to Charge Ratios per Medicaid Worksheet D-4 (as adjusted above) for acute services and the respective sub-providers Column 1, lines 37-68 times the charges based on MMIS paid charges mapped to respective Medicaid Worksheet D-4 Column 2, Lines 37-68.	Cost to Charge Ratios per Medicaid Worksheet D-3 (as adjusted above) for acute services and the respective sub-providers Column 1, lines 50-98 times the charges based on MMIS paid charges mapped to respective Medicaid Worksheet D-3 Column 2, Lines 50-98.
Non-Alabama Medicaid FFS Medicaid Eligible Outpatient Ancillary Cost for Acute and Sub-Provider Services	Non-Alabama Medicaid FFS Medicaid Eligible Outpatient Ancillary Cost for Acute and Sub-Provider Services
Cost to Charge Ratios per Medicaid Worksheet D Part V (as adjusted above) for acute services and the respective sub-providers Column 1, lines 37-68 times charges based on charges from the hospital's financial records mapped to the respective Medicaid Worksheet D Part V Column 5, Lines 37-68.	Cost to Charge Ratios per Medicaid Worksheet D Part V (as adjusted above) for acute services and the respective sub-providers Column 1, lines 50-98 times charges based on charges from the hospital's financial records mapped to the respective Medicaid Worksheet D Part V Column 4, Lines 50-98.

b. 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.

c. 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 plus the Medicaid portion of CRNA expense removed on Worksheet A-8 based on the Medicaid utilization of Medicaid charges divided by total charges, and the cost of Medicaid outpatient other services to determine the total Medicaid cost of services.

d. 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. The cost of services for inpatient routine care services, inpatient ancillary services, outpatient ancillary services, and transplant services will be determined as follows:

CMS Form 2552-96	*CMS Form 2552-10*
Adjustments Made to Cost Report Prior to Calculation of Cost	Adjustments Made to Cost Report Prior to Calculation of Cost
Graduate Medical Education reported on Worksheet B Part I Columns 22 and 23 lines 25-31, 33, and 37-94 shall be included in the calculation of cost of services for individuals with no source of third party insurance.	Graduate Medical Education reported on Worksheet B Part I Columns 21 and 223 lines 30-43 and 50-117 shall be included in the calculation of cost of services for individuals with no source of third party insurance.
Individuals With No Source of Third Party Insurance Routine Service Cost for Acute Services	Individuals With No Source of Third Party Insurance Routine Service Cost for Acute Services
Cost Per Diems per Medicaid Worksheet D-1 Part II Lines 38 and 42-47 (as adjusted above) to routine days based on mapping of routine days per hospital's financial records to Worksheet S-3, Part I Column 5, lines 6-12.	Cost Per Diems per Medicaid Worksheet D-1 Part II Lines 38 and 42-47 (as adjusted above) to routine days based on mapping of routine days per hospital's financial records to Worksheet S-3, Part I Column 7, lines 7-13.
Individuals With No Source of Third Party Insurance Routine Service Cost For Sub-Provider Services	Individuals With No Source of Third Party Insurance Routine Service Cost For Sub-Provider Services
Cost Per Diems per Medicaid Worksheet D-1 Part II Lines 38 (as adjusted above) on the respective Worksheet for the sub-provider times its respective days based on days from the hospital's financial records to the applicable Worksheet S-3, Part I Column 5, line 14.	Cost Per Diems per Medicaid Worksheet D-1 Part II Lines 38 (as adjusted above) on the respective Worksheet for the sub-provider times its respective days based on days from the hospital's financial records to the applicable Worksheet S-3, Part I Column 7, lines 16-18.
Individuals With No Source of Third Party Insurance Inpatient Ancillary Cost for Acute and Sub-Provider Services	Individuals With No Source of Third Party Insurance Inpatient Ancillary Cost for Acute and Sub-Provider Services
Cost to Charge Ratios per Medicaid Worksheet D-4 (as adjusted above) for acute services and the respective sub-providers Column 1, lines 37-68 times the charges based on charges from the hospital's financial records mapped to the respective Medicaid Worksheet D-4 Column 2, Lines 37-68.	Cost to Charge Ratios per Medicaid Worksheet D-3 (as adjusted above) for acute services and the respective sub-providers Column 1, lines 50-98 times the charges based on charges from the hospital's financial records mapped to the respective Medicaid Worksheet D-3 Column 2, Lines 50-98.
Individuals With No Source of Third Party Insurance Outpatient Ancillary Cost for Acute and Sub-Provider Services	Individuals With No Source of Third Party Insurance Outpatient Ancillary Cost for Acute and Sub-Provider Services
Cost to Charge Ratios per Medicaid Worksheet D Part V (as adjusted above) for acute services and the respective sub-providers Column 1, lines 37-68 times charges based on charges from the hospital's financial records mapped to the respective Medicaid Worksheet D Part V Column 5, Lines 37-68.	Cost to Charge Ratios per Medicaid Worksheet D Part V (as adjusted above) for acute services and the respective sub-providers Column 1, lines 50-98 times charges based on charges from the hospital's financial records mapped to the respective Medicaid Worksheet D Part V Column 4, Lines 50-98.

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 inpatient hospital service areas and all outpatient hospital service areas as defined in Attachment 3.1-A;
      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 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.

   i. 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 iii of this section.
   ii. 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 iii of this section.
   iii. 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 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.
   iv. 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 iii by the respective cost to charge ratio for the cost center as established in paragraph i.

v. 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 iii by the respective cost to charge ratios as established in paragraph i.

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 paragraph g of this Section.

2. Ambulance Services

a. The ambulance services cost identified from each hospital's most recently filed CMS Form 2552will be reported as follows:
CMS Form 2552-96: Worksheet C Part I, Line 65, Column 1
CMS Form 2552-10: Worksheet C Part I, Line 95, Column 1

b. The ambulance services cost related to graduate medical education activities reported as follows:
CMS Form 2552-96: Worksheet B Part I Line 65 Column 22 and 23
CMS Form 2552-10: Worksheet B Part I Line 95 Column 21 and 22

c. Total billed ambulance service charges are identified from each hospital's most recently filed CMS Form 2552 as follows:
CMS Form 2552-96: Worksheet C Part I, Line 65 Column 8
CMS Form 2552-10: Worksheet C Part I, Line 95 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 as follows:

CMS Form 2552-96	*CMS Form 2552-10*
Worksheet H-6 Lines 1-6 (Patient Services) and Lines 15-16 (Other Patient Services), Column 3 – Excluding Medical Social Services.	Worksheet H-3 Lines 1-6 (Patient Services) and Lines 15-16 (Other Patient Services), Column 3 – Excluding Medical Social Services.

b. The home health agency cost related to graduate medical education activities will be treated as follows:

CMS Form 2552-96	*CMS Form 2552-10*
Worksheet B Part I Line 71, Column 22 and 23.	Worksheet B Part I Line 101, Column 21 and 22.
Cost will be allocated based on total cost on Worksheet H-6 Lines 1-6.	Cost will be allocated based on total cost on Worksheet H-6 Lines 1-6.

c. Total billed home health agency visits are identified from each hospital's most recently filed CMS Form 2552 as follows:

CMS Form 2552-96	*CMS Form 2552-10*
Worksheet H-6 Lines 1-6, Column 4.	Worksheet H-6 Lines 1-6, Column 4.

d. Total billed home health agency charges are identified from each hospital's most recently filed CMS Form 2552as follows:

CMS Form 2552-96	*CMS Form 2552-10*
Worksheet H-6 Lines 15-16.2, Column 4.	Worksheet H-6 Lines 15-16, 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 2552Worksheet 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.

CMS Form 2552-96	*CMS Form 2552-10*
Worksheet B Part I Lines 93, Column 22 and 23.	Worksheet B Part I Lines 116, Column 21 and 22.

c. Total billed hospice unduplicated days are identified from each hospital's most recently filed CMS Form 2552 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 as follows:
CMS Form 2552-96: Worksheet C Part I, Line 56, Column 1
CMS Form 2552-10: Worksheet C Part I, Line 73, Column 1

Prescription pharmacy may have been moved from CMS Lines stated above by adjustments made by hospital or Medicare fiscal intermediary. If cost is reported on separate CMS Line than the CMS Line reported on the applicable CMS Form 2552 should be used from Worksheet C or Worksheet B Part I Column 27 for the CMS Form 2552-96 and Worksheet B Part I Column 26 per CMS Form 2552-10 if CMS Line is not reported on Worksheet C.

b. The pharmacy cost related to graduate medical education activities is as follows:
CMS 2552-96: Worksheet B Part I, Line 56, Column 22 and 23
CMS Form 2552-10: Worksheet B Part I, Line 73, Column 21 and 22

Prescription pharmacy may have been moved from CMS Lines stated above by adjustments made by hospital or Medicare fiscal intermediary. If cost is reported on separate CMS Line than the CMS Line reported on the applicable CMS Form 2552 should be used for graduate medical education reported on Worksheet B Part I.

c. Total billed pharmacy charges are identified from each hospital's most recently filed CMS Form 2552 as follows:
CMS Form 2552-96: Worksheet C Part I, Line 56, Column 8
CMS Form 2552-10: Worksheet C Part I, Line 73, Column 8

Prescription pharmacy may have been moved from CMS Lines stated above by adjustments made by hospital or Medicare fiscal intermediary. If cost is reported on separate CMS Line than the CMS Line reported on the applicable CMS Form 2552 should be used from Worksheet C Column 8 or prescription pharmacy charges from hospital's financial records should be used to determine total charges if prescription pharmacy is not reported on Worksheet C.

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 as follows:

CMS Form 2552-96	*CMS Form 2552-10*
Worksheet I-4 Lines 1-10, Column 2.	Worksheet I-4 Lines 1-10, Column 2.

b. The outpatient renal dialysis services cost related to graduate medical education activities that are reported as follows:

CMS Form 2552-96	*CMS Form 2552-10*
Worksheet B Part I Line 57 and Line 64, Column 22 and 23. Cost will be allocated based on total cost on Worksheet I-4 Lines 1-10.	Worksheet B Part I Line 74, Column 21 and 22. Cost will be allocated based on total cost on Worksheet I-4 Lines 1-10.

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 as follows:

CMS Form 2552-96	*CMS Form 2552-10*
Worksheet I-4 Lines 1-10, Column 4.	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 as follows:

CMS Form 2552-96	*CMS Form 2552-10*
Worksheet M-3 Line 3 Column 1 for allowable cost excluding vaccines.	Worksheet M-3 Line 3 Column 1 for allowable cost excluding vaccines.
Worksheet M-4 Line 10, Column 1 for cost of pneumococcal vaccine injections	Worksheet M-4 Line 10, Column 1 for cost of pneumococcal vaccine injections
Worksheet M-4 Line 10, Column 2 for cost of influenza vaccine injections	Worksheet M-4 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 is as follows:

CMS Form 2552-96	*CMS Form 2552-10*
Worksheet B Part I Line 63, Column 22 and 23.	Worksheet B Part I Line 88 or 89, Column 21 and 22.

c. Total billed rural health center/federal qualified health center visits/vaccines are identified from each hospital's most recently filed CMS Form 2552 as follows:

CMS Form 2552-96	*CMS Form 2552-10*
Worksheet M-3 Part I Line 6 Column 1 for total adjusted clinic visits.	Worksheet M-3 Part I Line 6 Column 1 for total adjusted clinic visits.
Worksheet M-4 Part I Line 11 Column 1 for total number of pneumococcal vaccine injections	Worksheet M-4 Part I Line 11 Column 1 for total number of pneumococcal vaccine injections
Worksheet M-4 Part 1 Line 11 Column 2 for total number of influenza vaccine injections	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 d by the cost per visit/cost per vaccine injection ratio as established in paragraph e.

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

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

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

6. 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 MAC 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 final reconciliation will be completed by the end of the third CMS Form 64 quarter that follows the CMS Form 64 quarter where the of the filing of the last electronic CMS cost report filed by a State government owned or operated or a non-State government owned or operated hospital to its applicable MAC that included the September 30th fiscal year end of the State occurs.

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.

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

a. The cost of services for inpatient routine care services, inpatient ancillary services, and outpatient ancillary services will be determined as follows:

CMS Form 2552-96	*CMS Form 2552-10*
Adjustments Made to Cost Report Prior to Calculation of Cost	Adjustments Made to Cost Report Prior to Calculation of Cost
Graduate Medical Education reported on Worksheet B Part I Columns 22 and 23 lines 25-31, 33, and 37-94 shall be included in the calculation of cost of services for individuals with no source of third party insurance.	Graduate Medical Education reported on Worksheet B Part I Columns 21 and 223 lines 30-43 and 50-117 shall be included in the calculation of cost of services for individuals with no source of third party insurance.
Non-Alabama Medicaid FFS Medicaid Eligible Routine Service Cost For Sub-Provider Services	Non-Alabama Medicaid FFS Medicaid Eligible Routine Service Cost For Sub-Provider Services
Cost Per Diems per Medicaid Worksheet D-1 Part II Lines 38 and 42-47 (as adjusted above) to routine days based on mapping of routine days per hospital's financial records to Worksheet S-3, Part I Column 5, lines 6-12.	Cost Per Diems per Medicaid Worksheet D-1 Part II Lines 38 and 42-47 (as adjusted above) to routine days based on mapping of routine days per hospital's financial records to Worksheet S-3, Part I Column 7, lines 7-13.
Non-Alabama Medicaid FFS Medicaid Eligible Routine Service Cost For Sub-Provider Services	Non-Alabama Medicaid FFS Medicaid Eligible Routine Service Cost For Sub-Provider Services
Cost Per Diems per Medicaid Worksheet D-1 Part II Lines 38 (as adjusted above) on the respective Worksheet for the sub-provider times its respective days based on days from the hospital's financial records to the applicable Worksheet S-3, Part I Column 5, line 14.	Cost Per Diems per Medicaid Worksheet D-1 Part II Lines 38 (as adjusted above) on the respective Worksheet for the sub-provider times its respective days based on days from the hospital's financial records to the applicable Worksheet S-3, Part I Column 7, lines 16-18.
Non-Alabama Medicaid FFS Medicaid Eligible Inpatient Ancillary Cost for Acute and Sub-Provider Services	Non-Alabama Medicaid FFS Medicaid Eligible Inpatient Ancillary Cost for Acute and Sub-Provider Services
Cost to Charge Ratios per Medicaid Worksheet D-4 (as adjusted above) for acute services and the respective sub-providers Column 1, lines 37-68 times the charges based on charges from the hospital's financial records mapped to the respective Medicaid Worksheet D-4 Column 2, Lines 37-68.	Cost to Charge Ratios per Medicaid Worksheet D-3 (as adjusted above) for acute services and the respective sub-providers Column 1, lines 50-98 times the charges based on charges from the hospital's financial records mapped to the respective Medicaid Worksheet D-3 Column 2, Lines 50-98.
Non-Alabama Medicaid FFS Medicaid Eligible Outpatient Ancillary Cost for Acute and Sub-Provider Services	Non-Alabama Medicaid FFS Medicaid Eligible Outpatient Ancillary Cost for Acute and Sub-Provider Services
Cost to Charge Ratios per Medicaid Worksheet D Part V (as adjusted above) for acute services and the respective sub-providers Column 1, lines 37-68 times charges based on charges from the hospital's financial records mapped to the respective Medicaid Worksheet D Part V Column 5, Lines 37-68	Cost to Charge Ratios per Medicaid Worksheet D Part V (as adjusted above) for acute services and the respective sub-providers Column 1, lines 50-98 times charges based on charges from the hospital's financial records mapped to the respective Medicaid Worksheet D Part V Column 4, Lines 50-98.

b. 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 above.

c. Combining the cost of Medicaid routine services, cost of Medicaid inpatient ancillary services, cost of Medicaid outpatient ancillary services plus the Medicaid portion of CRNA expense removed on Worksheet A-8 based on the Medicaid utilization of Medicaid charges divided by total charges and the cost of Medicaid outpatient other services to determine the total Medicaid cost of services.

d. 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. The cost of services for inpatient routine care services, inpatient ancillary services, outpatient ancillary services, and transplant services will be determined as follows:

CMS Form 2552-96	*CMS Form 2552-10*
Adjustments Made to Cost Report Prior to Calculation of Cost	Adjustments Made to Cost Report Prior to Calculation of Cost
Graduate Medical Education reported on Worksheet B Part I Columns 22 and 23 lines 25-31, 33, and 37-94 shall be included in the calculation of cost of services for individuals with no source of third party insurance.	Graduate Medical Education reported on Worksheet B Part I Columns 21 and 223 lines 30-43 and 50-117 shall be included in the calculation of cost of services for individuals with no source of third party insurance.
Individuals With No Source of Third Party Insurance Routine Service Cost For Acute Services	Individuals With No Source of Third Party Insurance Routine Service Cost For Acute Services
Cost Per Diems per Medicaid Worksheet D-1 Part II Lines 38 and 42-47 (as adjusted above) to routine days based on mapping of routine days per hospital's financial records to Worksheet S-3, Part I Column 5, lines 6-12	Cost Per Diems per Medicaid Worksheet D-1 Part II Lines 38 and 42-47 (as adjusted above) to routine days based on mapping of routine days per hospital's financial records to Worksheet S-3, Part I Column 7, lines 7-13.
Individuals With No Source of Third Party Insurance Routine Service Cost For Sub-Provider Services	Individuals With No Source of Third Party Insurance Routine Service Cost For Sub-Provider Services
Cost Per Diems per Medicaid Worksheet D-1 Part II Lines 38 (as adjusted above) on the respective Worksheet for the sub-provider times its respective days based on days from the hospital's financial records to the applicable Worksheet S-3, Part I Column 5, lines 14.	Cost Per Diems per Medicaid Worksheet D-1 Part II Lines 38 (as adjusted above) on the respective Worksheet for the sub-provider times its respective days based on days from the hospital's financial records to the applicable Worksheet S-3, Part I Column 7, lines 16-18.

Individuals With No Source of Third Party Insurance Inpatient Ancillary Cost for Acute and Sub-Provider Services	Individuals With No Source of Third Party Insurance Inpatient Ancillary Cost for Acute and Sub-Provider Services
Cost to Charge Ratios per Medicaid Worksheet D-4 (as adjusted above) for acute services and the respective sub-providers Column 1, lines 37-68 times the charges based on charges from the hospital's financial records mapped to the respective Medicaid Worksheet D-4 Column 2, Lines 37-68.	Cost to Charge Ratios per Medicaid Worksheet D-3 (as adjusted above) for acute services and the respective sub-providers Column 1, lines 50-98 times the charges based on charges from the hospital's financial records mapped to the respective Medicaid Worksheet D-3 Column 2, Lines 50-98.
Individuals With No Source of Third Party Insurance Outpatient Ancillary Cost for Acute and Sub-Provider Services	Individuals With No Source of Third Party Insurance Outpatient Ancillary Cost for Acute and Sub-Provider Services
Cost to Charge Ratios per Medicaid Worksheet D Part V (as adjusted above) for acute services and the respective sub-providers Column 1, lines 37-68 times charges based on charges from the hospital's financial records mapped to the respective Medicaid Worksheet D Part V Column 5, Lines 37-68.	Cost to Charge Ratios per Medicaid Worksheet D Part V (as adjusted above) for acute services and the respective sub-providers Column 1, lines 50-98 times charges based on charges from the hospital's financial records mapped to the respective Medicaid Worksheet D Part V.

b. Determining the cost of uninsured other outpatient services based on methodology discussed under this protocol for the Interim Disproportionate Share Hospital (DSH) Limit Post Reporting Year in this exhibit.

c. Combining the cost of uninsured routine services, cost of uninsured inpatient ancillary services, cost of uninsured outpatient ancillary services plus the uninsured portion of CRNA expense removed on Worksheet A-8 based on the uninsured utilization based on uninsured charges divided by total charges, and the and the cost of uninsured other outpatient services to determine the total cost of services provided to individuals with no source of third party insurance.

d. 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.

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

METHOD FOR PAYMENT OF REASONABLE COSTS INPATIENT HOSPITAL SERVICES

Effective Date: 10/01/11

(f) For the period from October 1, 2011, to September 30, 2013, 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 non-state government 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 non-state government and state owned disproportionate share hospitals as defined on Attachment 4.19-A Page 3A shall receive an amount such that the sum of inpatient hospital payments, outpatient payments, and the certified public expenditure related to disproportionate share hospital cost do not exceed each hospital's DSH limit under 1923(g) of the Social Security Act. Medicaid cost for these services shall be allowable cost determined in accordance with the Medicare Principles of Reimbursement, the applicable CMS 2552 and the DSH final rule effective January 19, 2009 which states on page 77913 "(t)he treatment of inpatient and outpatient services provided to the uninsured and the underinsured...must be consistent with the definition of inpatient and/or outpatient services under the approved Medicaid State Plan."

(4) Eligible hospitals administered by the Department of Mental Health shall be paid an amount of DSH funds not to exceed the DSH IMD Allotment published annually by CMS.

(5) The disproportionate share hospital allotment remaining after disproportionate share hospital payments have been made to non-state government 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 who do not exceed their estimated disproportionate share hospital payment limit calculated at the beginning of the State Fiscal Year. For the State Fiscal Year Ended September 30, 2012, the Children's Hospital of Alabama shall receive a DSH payment in the sum to not exceed $1. The remaining privately owned hospitals shall be paid an amount 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 the State Fiscal Year 2007, divided by the total eligible uncompensated care costs for all eligible privately owned DSH Hospitals (excluding the Children's Hospital of Alabama) during State Fiscal Year 2007.

For the State Fiscal Year Ended September 30, 2013, the Children's Hospital of Alabama and Jackson Hospital and Clinics shall receive a DSH payment in the sum to not exceed $1.50 for each day incurred for individuals with no third party insurance during the State Fiscal Year 2007. The remaining privately owned hospitals shall be paid an amount 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 the State Fiscal Year 2007, divided by the total eligible uncompensated care costs for all eligible privately owned DSH Hospitals (excluding the Children's Hospital of Alabama and Jackson Hospital and Clinics) during State Fiscal Year 2007.

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

(7) As required by Section 1923(j) of the Social Security Act related to auditing and reporting of DSH hospital payments, Alabama Medicaid will implement procedures to comply with DSH Hospital Payments final rule issued in the December 19, 2008, Federal Register, with effective date of January 19, 2009, to ensure that the hospital specific DSH limits have not been exceeded.

Any reconciliation of the Certified Public Expenditures for State owned and operated hospitals or non-State owned and operated hospitals outlined in Attachment 4.19-A Exhibit C for uncompensated cost of care for services provided to individuals with no source of third party insurance that shifts the amount certified for such cost by a hospital to another hospital will be considered a redistribution of DSH payments.

Any reconciliations of the CPE where the State must return the Federal Share of the Uncompensated cost of care for services provide to individuals with no source of third party insurance to the Federal Government will constitute a re-payment of DSH monies for State owned and operated hospitals or non-State owned and operated hospitals that exceeded their DSH limit and contributed to the repayment of funds under the CPE reconciliation.

The Medicaid Agency will recoup funds from any privately owned or operated hospital that exceeded its hospital specific DSH limit as a result of audits or other corrections and shall redistribute to other eligible hospitals within the state, provided each hospital remains below their hospital specific DSH limit in the following manner:

(a) Funds shall be redistributed from a hospital to other private hospitals with common ownership;
(b) Funds shall be redistributed to the private hospital with the highest Medicaid Inpatient Utilization Rate (MIUR). Any remaining funds available for redistribution shall be redistributed to other private hospitals in the order of MIUR from highest to lowest.

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

METHOD FOR PAYMENT OF REASONABLE COSTS INPATIENT HOSPITAL SERVICES

Effective Date: 10/01/11

(j) For the period October 1, 2011, through September 30, 2013, 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 2012 and 2013 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, 2012 and 2013.

(2) Base (per diem) payments for state fiscal years 2012 and 2013 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 2009 that ceases to operate as a hospital, beginning on the date that the facility ceases to operate as a hospital.

(3) Interim payments for hospitals that qualify for and file Certified Public Expenditures will consist of base per diem payments and quarterly cost adjustment payments.

(4) Base (per diem) payments will be reviewed on a 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).

(5) Quarterly access payments will be made to privately owned and operated hospitals as outlined in paragraph (l).

(k) For the period October 1, 2011, through September 30, 2013, the amount available for inpatient hospital access payments shall be calculated as follows:

(1) Privately owned and operated hospital's CMS Form 2552-96 cost reports that had an end date during the calendar year 2009 were obtained.

(2) A Medicare payment to charge ratio was determined from each cost report by obtaining the following information from the CMS Form 2552-96 cost reports for each hospital:

(a) Medicare Payments were obtained from the following CMS Lines:

1. Acute Care Services: Sum of Worksheet E Part A Lines 17, 19, 20, and 26, less 21.01.
2. Psych Hospitals: Sum of Worksheet E-3 Part I Lines 5, 7, 9, and 17, less 11.01.
3. Children's Hospitals: Sum of Worksheet E-3 Part I Lines 5, 7, 9, and 17, less 11.01.
4. Critical Access Hospitals: Sum of Worksheet E-3 Part II Lines 17, 20, 23 and 30, less 11.01.
5. Sub-provider units: Sum of Worksheet E-3 Part I Lines 5, 7, 9, and 17, less 11.01.
6. 2009 Cost Report Year Portion of Medicare Rural Floor Budget Neutrality Adjustment Settlement With CMS.

(b) Medicare Charges were obtained from the following CMS Lines:

1. Acute Care Services: Sum of Worksheet D-4 Column 2 Lines 25-30 and 103.
2. Psych Hospitals: Sum of Worksheet D-4 Column 2 Lines 25-30 and 103.
3. Children's Hospitals: Sum of Worksheet D-4 Column 2 Lines 25-30 and 103.
4. Critical Access Hospitals: Sum of Worksheet D-4 Column 2 Lines 25-30 and 103.
5. Sub-provider units: Worksheet D-4 Column 2 Line 103 plus Worksheet D-1 Line 28 times the Medicaid utilization for the applicable sub-provider (Days per Worksheet S-3 Part I Line 14 Column 4 ÷ Worksheet S-3 Part I Line 14 Column 6).

(c) For private psychiatric hospitals who do not file Medicare cost reports, the Medicaid cost report will be used to calculate a payment to charge ratio.

(3) The payment to charge ratio calculated in Step (2) will be multiplied by the Medicaid charges obtained from the State's MMIS system for 2009 claims which would be covered during SFY 2012 and SFY 2013 to determine the amount Medicare would have paid for Medicare services during each hospital's cost report ended during the calendar year 2009.

(4) For cost reports ending during calendar year 2009, the amount determined in Step (3) will be multiplied by the product of the CMS Market Basket for Medicare inpatient prospective payment system (3.60%) and a utilization increase based on change in paid days from SFY 2008 to SFY 2009 for inpatient hospitals in Alabama (3.39%). This product will be multiplied by the number of months each hospital's cost report period mid-point to the end of the State Fiscal Year 2009:

Cost Report Ended	CR Adjustment Rate
January 31, 2009	1.1667
February 28, 2009	1.0833
March 31, 2009	1.0000
April 30, 2009	0.9167
June 30, 2009	0.7500
July 31, 2009	0.5833
September 30, 2009	0.5000
December 31, 2009	0.2500

(5) To determine the estimated total Medicare payments for Medicaid services for State Fiscal Year 2012 and State Fiscal Year 2013, the SFY 2009 Medicare payments in relation to Medicaid services determined in Step (4) will be multiplied by the product of an increase in cost due to the CMS Market basket Inpatient Hospital PPS (http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/Downloads/mktbskt-actual.pdf) and a utilization increase using actual increases in paid days for SFYs 2010 and 2011 with a linear regression being completed for SFY 2012 and SFY 2013 using actual increases for SFY 2008 through SFY 2011. These increases are as follows:

SFY	State Fiscal Year Factor	IPPS Market Basket	Utilization Increase	Overall Increase Factor
2010	0.50	2.10%	3.71%	1.0292
2011	1.00	2.60%	3.66%	1.0636
2012	1.00	3.00%	3.49%	1.0659
2013	1.00	2.70%	3.37%	1.0616

(6) The Medicaid allowed amount for claims included in Step (3) was obtained from the MMIS for cost reporting periods ending in calendar year 2009. The utilization increase identified in Step (4) and the cost report factors in Step (4) was applied to the Medicaid allowed amount to standardize all hospital payments to SFY 2009. The Medicaid payments for SFY 2009 were multiplied by the utilization increase amount in Step (5) to determine the Medicaid payments for SFY 2012 and SFY 2013.

(7) The difference between Medicare Payments for Medicaid Services determined in Step (5) and the Medicaid payments in Step (6) will be the Upper Payment Limit amount set forth in 42 CFR 447.272 for SFY 2012 and 2013.

(l) For the period October 1, 2011, through September 30, 2013, in addition to any other funds paid to private 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 access payment to privately owned and operated hospitals determined on a quarterly basis by the Alabama Medicaid Agency that complies with paragraph (4) below.

(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 private hospital access payments shall be made on a quarterly basis.

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

(m) For the period October 1, 2011, through September 30, 2013, 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 $177 per Medicaid inpatient day paid in state fiscal year 2009.

(n) The additional payments outlined in paragraph (l) and paragraph (m) shall not exceed the Upper Payment Limit calculated in paragraph (k)(7).

(o) For the period October 1, 2011, through September 30, 2013, 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) 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)(3).

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

METHOD FOR PAYMENT OF REASONABLE COSTS INPATIENT HOSPITAL SERVICES

Effective Date: 10/01/11

(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, 2011, through September 30, 2013, 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 and 2552-10 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").

(p) Privately Owned and Operated Hospital: For purposes of Medicaid base, access and DSH payments for the period from October 1, 2011, through September 30, 2013, 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 per diem payments, quarterly adjustment and DSH payments for the period from October 1, 2011, through September 30, 2013, 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 per diem payments, quarterly adjustment and DSH payments for the period from October 1, 2011, through September 30, 2013, 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.