

**STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
MED-QUEST DIVISION**

PUBLIC NOTICE

Pursuant to 42 C.F.R. §447.205, the Department of Human Services (DHS), Med-QUEST Division (MQD) hereby notifies the public that the MQD intends to submit a State Plan Amendment (SPA) to the Centers for Medicare and Medicaid Services (CMS).

The proposed amendment to Attachment 4.19-A pg. 41-43(a) of the Hawaii State Medicaid plan changes the payment methodology for distribution of Medicaid Disproportionate Share Hospital(s) (DSH) funds to reflect a more equitable distribution.

Under Provisions of federal law, the state is required to issue public notice of proposed changes in statewide methods and standards for setting Medicaid payment rates.

SPA 21-0014 is expected to have minimal effect on the annual aggregate expenditures as no portion of payments are returned to the state. The state share is from appropriations from the Legislature directly to the Medicaid agency.

The proposed change will be submitted for review to the federal government as a Medicaid SPA.

The SPA pages are attached to this notice.

For a copy of the proposed changes, please contact:

By email: PPDO@dhs.hawaii.gov (Please identify in the subject line: State Plan Amendment 21-0014)

By mail:

Department of Human Services
Med-QUEST Division
Attention: Policy and Program Development Office
P.O Box 700190
Kapolei, Hawaii 96709

A printed copy of the proposed changes and special accommodations (i.e., interpreter, large print or taped materials) can be arranged if requested by contacting the Policy and Program Development Office at (808) 692-8058 no later than seven (7) working days before the comment period ends.

Comments should be received **within 30 days** from the time this notice is posted. Individuals may submit written comments using the following methods:

By email: PPDO@dhs.hawaii.gov (Please identify in the subject line: State Plan Amendment 21-0014)

By mail:

Department of Human Services
Med-QUEST Division
Attention: Policy and Program Development Office
P.O Box 700190
Kapolei, Hawaii 96709

DEPARTMENT OF HUMAN SERVICES, MED-QUEST DIVISION
JUDY MOHR PETERSON, PhD
MED-QUEST DIVISION ADMINISTRATOR

- c. In the event that the aggregate uncompensated care costs of the governmental DSH hospitals exceed the maximum allotment available for the governmental DSH hospitals, each governmental DSH hospital's uncompensated costs shall be reduced pro rata so that the aggregate of uncompensated costs is equal to the maximum allotment available for the governmental DSH hospitals. Any overpayment to a governmental hospital, based on the results of the DSH audit and reporting requirements per 42 CFR 447.299 and 42 CFR 455 Subpart D or otherwise, including the determination of a hospital's uncompensated care cost limit and its DSH qualification using actual period data, will be recouped from the hospital and redistributed to other governmental DSH hospitals based on the proportion of each remaining hospital's uncompensated care cost to the aggregate of the remaining hospitals' uncompensated care costs.
3. With respect to DSH state plan rate year ending September 30, 2013 and after:
- a. DSH providers (which do not include governmental DSH providers) shall receive payments from a pool of funds which equal to the total computable amount of Hawaii's annual DSH allotment for each respective fiscal year, per Section 1923(f) of the Social Security Act, reduced by the twenty-five dollars (\$25.00) total computable amount for governmental DSH providers specified in paragraph 3.b below.
 - 1. The distribution of funds from the pool shall be on the basis of each qualifying hospital's proportionate share of uncompensated costs (as defined in paragraph A-4 above), as reported on the most recent available hospital cost reports.

Effective 10/01/2021, only for purposes of distribution of funds, each hospital's uncompensated costs will be adjusted as follows:

 - a. Medicaid uncompensated costs will be limited to lower of Medicaid shortfall or all payments received for Medicaid claims.
 - b. The uninsured uncompensated costs will be limited to lower of uninsured shortfall or Net Hospital Inpatient and Outpatient revenue less Medicaid Net Hospital Inpatient and Outpatient revenue.
 - 2. In no event shall the total payments to a DSH provider for any DSH state plan rate year exceed the uncompensated care costs, as defined in paragraph A.4, of the provider for the same DSH state plan rate year. If the provider has uncompensated care costs attributable to DSH state plan rate year that are less than the amount of the payments that would be made to that provider pursuant to subparagraph (1) above (or to the redistribution described in this sentence), the payments to that provider shall be reduced to the amount of its uncompensated care costs attributable to DSH state plan rate

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year, and the difference shall be distributed to the remaining DSH providers in accordance with subparagraph (1) above.

3. Any overpayment to a DSH hospital, based on the results of the DSH audit and reporting requirements per 42 CFR 447.299 and 42 CFR 455 Subpart D or otherwise, including the determination of a hospital's uncompensated care cost limit and its DSH qualification using actual period data, will be recouped from the hospital and redistributed to other DSH hospitals in accordance with subparagraph (1) above.

- b. Governmental DSH providers shall receive payments from a pool of funds in the total computable amount of twenty-five dollars (\$25.00).

1. The distribution of funds from the pool shall be on the basis of each qualifying hospital's uncompensated care cost (as defined in paragraph A-4 above).
2. The federal share of the DSH payments to governmental hospitals under this paragraph b., when combined with the federal share of the DSH payment made to DSH hospitals under paragraph 3.a., shall not exceed the federal share of Hawaii's annual DSH allotment for each respective fiscal year, per Section 1923(f) of the Social Security Act.

4. No payment will be made to any hospital in excess of its total inpatient and outpatient hospital uncompensated care costs.

C. PAYMENT METHOD

Payments will be made in up to four installments for each DSH state plan rate year.

DSH payments for governmental DSH providers will be reconciled in accordance with the methodology set forth in the Protocol referred to in Section E.

D. SOURCE OF DATA

The calculations to be made in determining the payment amounts in accordance with section B.1. above shall be based on cost reports for each hospital's most current fiscal year concluded by June 30, 2011 for DSH state plan rate year ending September 30, 2012. For all subsequent state plan rate years, the payment amount calculations in section B.3.a shall also follow the same timing (e.g., cost reports for each hospital's most current fiscal year concluded by June 30, 2012 for DSH state plan rate year ending September 30, 2013). The calculations to be made in determining the payment amounts in accordance with sections B.2. and B.3.b. above shall be based on sources as specified in the cost protocol in section E below.

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E. COST PROTOCOL

Uncompensated cost of government DSH providers will be determined in accordance with the following Cost Protocol:

Government-Owned Hospital Uncompensated Care Cost (UCC) Protocol**Introduction**

This protocol directs the method that will be used to determine uncompensated care (UCC) payments to government-owned hospitals as allowed by this Section VIII (Disproportionate Share Payments).

Summary of Medicare Cost Report Worksheets

Expenditures will be determined according to costs reported on the hospitals' 2552 Medicare cost reports as follows:

Worksheet A

The hospital's trial balance of total expenditures, by cost center. The primary groupings of cost centers are:

- (i) overhead;
- (ii) routine;
- (iii) ancillary;
- (iv) outpatient;
- (v) other reimbursable; and
- (vi) non-reimbursable.

Worksheet A also includes A-6 reclassifications (moving cost from one cost center to another) and A-8 adjustments (which can be increasing or decreasing adjustments to cost centers). Reclassifications and adjustments are made in accordance with Medicare reimbursement principles.

Worksheet B

Allocates overhead (originally identified as General Services Cost Centers, lines 1-24 of Worksheet A) to all other cost centers, including the non-reimbursable costs identified in lines 96 through 100.

Worksheet C

Computation of the cost-to-charge ratio for each cost center. The total cost for each cost center is derived from Worksheet B, after the overhead allocation. The total charge for each cost center is determined from the hospitals records. The cost to charge ratios are used in the Worksheet D series to determine program costs.

The governmentally operated hospitals (hospital) will utilize the Medicare cost report to determine uncompensated care costs described in the subsequent instructions. The above Medicare cost-to-charge ratio will be applied to the uncompensated care population program charges to determine cost. The cost will be reduced by actual payments received to determine the hospital's uncompensated care cost. Any DSH payments to hospitals by the

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State related to this DSH computation will not be reflected in the payment received to determine hospitals' uncompensated care cost. Non-Medicaid payments, funding and subsidies made by a state or unit of local government shall not be offset (e.g. state-only, local-only, or state-local health programs).

Notes:

For the purpose of utilizing the Medicare cost report to determine uncompensated care costs described in the subsequent instructions, the following terms and methodology are defined as follows:

The term "filed Medicare cost report" refers to the cost report that is submitted by the hospital to Medicare Fiscal Intermediary and is due five months after the end of the hospital's fiscal year end period.

The term "finalized Medicare cost report" refers to the cost report that is settled by the Medicare Fiscal Intermediary with the issuance of Notice of Program Reimbursement (NPR).

The "Uncompensated care costs (UCC)" includes covered inpatient and outpatient hospital services cost from the Medicaid Fee For Service (Medicaid FFS), QUEST Integration (QI), and Uninsured population, less payments received from Medicaid FFS, (QI), and uninsured patients.

Nothing in this document shall be construed to eliminate or otherwise limit a hospital's right to pursue all administrative and judicial review available under the Medicare program. Any revision to the finalized Audit Report as a result of appeals reopening, or reconsideration shall be incorporated into the final determination.

Determination of Allowable Payment to cover Uncompensated Care Costs (UCC)

To determine governmentally operated hospital's (hospital) allowable UCC, the following steps must be taken to ensure Federal financial participation (FFP):

Annual Payment

Each hospital's annual DSH payments will be based on its filed Medicare cost reports for the spending year to which the payments apply or, if not available, for the most recent year for which a report is available. If a prior year cost report is used for the interim payment purposes, the annual payment will be determined as described below but using the data from that prior period, and such interim payment will then be first reconciled to the annual payment computed from the spending cost reporting period, as described below, once that spending year Medicare cost report is filed by the hospital.

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The annual payment is based on the calculation of inpatient and outpatient program costs using the cost center per diems and cost-to-charge ratios derived from its filed Medicare cost report for the service period. Days, charges, and payments for Medicaid FFS services originating from the provider's auditable records will be reconciled to MMIS paid claims records. Medicaid managed care and uninsured days, charges, and payments will originate from the provider's auditable records.

For each inpatient hospital routine cost center, a per diem is calculated by dividing total costs of the cost center (from ws B, part I, column 25) by total days of the cost center (from ws S-3, Part I, column 6). For each ancillary hospital cost center, a cost to charge ratio is calculated by dividing the total cost of the cost center (from ws B, Part I, column 25) by the total charges of the cost center (from ws C, Part I, column 8). The Adult and Pediatric (A&P) routine per diem, in accordance with CMS 2552 worksheet D-1, should be computed by including observation bed days in the total A&P patient day count and excluding swing bed nursing facility costs and non-medically necessary private from differential cost from the A&P costs.

For inpatient UCC cost computation, each routine hospital cost center's per diem is multiplied by the cost center's number of eligible UCC days, and each ancillary hospital cost center's cost-to-charge ratio is multiplied by the cost center's UCC-eligible inpatient charges. Eligible UCC days and charges pertain only to the UCC populations and services and exclude any non-hospital services such as physician/practitioner professional services. The sum of each cost center's inpatient hospital UCC cost is the hospital's inpatient UCC cost prior to the application of payment/revenue offsets.

For outpatient UCC cost computation, each ancillary hospital cost center's cost-to-charge ratio is multiplied by the cost center's UCC-eligible outpatient charges. Eligible UCC charges pertain only to the UCC populations and services as defined in the STCs and exclude any non-hospital services such as physician/practitioner professional services. The sum of each cost center's outpatient hospital UCC cost is the hospital's outpatient UCC cost prior to the application of payment/revenue offsets.

The cost computed above will be offset by all applicable payments received for the Medicaid and uninsured services included in the UCC computation and then reconciled to the interim quarterly UCC payments made.

Payments that are made independent of the claims processing system for hospital services of which the cost are included in the program costs described above, including payments from managed care entities, for serving QUEST Integration (QI) enrollees, will be included in the total program payments under this annual initial reconciliation process. Non-Medicaid payments, funding and subsidies made by a state or unit of local government will not be included in the total program payment offset.

Final Reconciliation Payment

Each hospital's annual DHS payment in a spending year will also be subsequently reconciled to its finalized Medicare cost report for the respective cost reporting period. The hospital will adjust, as necessary, the aggregate amount of UCC reported under the final reconciliation payment.

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If, at the end of the final reconciliation process, it is determined that expenditures claimed were overstated or understated, such overpayment or underpayment will be properly reported to the federal government. The same methodology detailed in the annual payment will be used for the final reconciliation payment. The final reconciliation payments are based on the recalculation of program costs using the cost center's per diem and cost-to-charge ratios from the finalized Medicare cost report for the services period. The hospital will update the program charges to include only paid claims from Medicaid FFS and QUEST Integration (QI) in computing program cost for the reporting period. For the uninsured population, the hospital will update any payment made by or on behalf of the uninsured. Days, charges, and payments for Medicaid FFS originating from the provider's auditable records will be reconciled to MMIS paid claims records. Medicaid managed care and uninsured days, charges, and payment will originate from the providers auditable records. The hospital will report inpatient and outpatient UCC based on program data related to medical services that are eligible for Federal financial participation for the uncompensated care costs under this DSH process.

The inpatient and outpatient costs computed above will be offset by all applicable payments received for the Medicaid and uninsured services included in the UCC computation and then reconciled to the interim DSH payments.

Payment that are made independent of the claims processing system for hospital services of which the costs are included in the program costs described above, must be included in the total program payments under this final reconciliation process. Non-Medicaid payments, findings, and subsidies made by a state or unit of local government shall not be offset. Federal matching funds may be claimed for UCCs up to the hospitals' eligible uncompensated costs as determined in this process.

The final reconciliation described above will be performed and completed within six months after the issuance of all of the finalized government-owned hospital Medicare cost reports from each respective fiscal year. The State is responsible to ensure the accuracy of DSH amounts used for federal claiming.

If a hospital financial and cost reporting period does not coincide with the Medicaid State plan period for which the DSH UCC cost is being computed, the hospital's cost will be the computed based on its full cost reporting period, as prescribed above, and then allocated pro rate to a State plan period based on the number of months covered by the financial or cost reporting period that are included in the Medicaid State plan period.

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- c. In the event that the aggregate uncompensated care costs of the governmental DSH hospitals exceed the maximum allotment available for the governmental DSH hospitals, each governmental DSH hospital's uncompensated costs shall be reduced pro rata so that the aggregate of uncompensated costs is equal to the maximum allotment available for the governmental DSH hospitals. Any overpayment to a governmental hospital, based on the results of the DSH audit and reporting requirements per 42 CFR 447.299 and 42 CFR 455 Subpart D or otherwise, including the determination of a hospital's uncompensated care cost limit and its DSH qualification using actual period data, will be recouped from the hospital and redistributed to other governmental DSH hospitals based on the proportion of each remaining hospital's uncompensated care cost to the aggregate of the remaining hospitals' uncompensated care costs.
3. With respect to DSH state plan rate year ending September 30, 2013 and after:
- a. DSH providers (which do not include governmental DSH providers) shall receive payments from a pool of funds which equal to the total computable amount of Hawaii's annual DSH allotment for each respective fiscal year, per Section 1923(f) of the Social Security Act, reduced by the twenty-five dollars (\$25.00) total computable amount for governmental DSH providers specified in paragraph 3.b below.
 - 1. The distribution of funds from the pool shall be on the basis of each qualifying hospital's proportionate share of uncompensated costs (as defined in paragraph A-4 above), as reported on the most recent available hospital cost reports.

Effective 10/01/2021, only for purposes of distribution of funds, each hospital's uncompensated costs will be adjusted as follows:

 - a. Medicaid uncompensated costs will be limited to lower of Medicaid shortfall or all payments received for Medicaid claims.
 - b. The uninsured uncompensated costs will be limited to lower of uninsured shortfall or Net Hospital Inpatient and Outpatient revenue less Medicaid Net Hospital Inpatient and Outpatient revenue.
 - 2. In no event shall the total payments to a DSH provider for any DSH state plan rate year exceed the uncompensated care costs, as defined in paragraph A.4, of the provider for the same DSH state plan rate year. If the provider has uncompensated care costs attributable to DSH state plan rate year that are less than the amount of the payments that would be made to that provider pursuant to subparagraph (1) above (or to the redistribution described in this sentence), the payments to that provider shall be reduced to the amount of its uncompensated care costs attributable to DSH state plan rate

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year, and the difference shall be distributed to the remaining DSH providers in accordance with subparagraph (1) above.

3. Any overpayment to a DSH hospital, based on the results of the DSH audit and reporting requirements per 42 CFR 447.299 and 42 CFR 455 Subpart D or otherwise, including the determination of a hospital's uncompensated care cost limit and its DSH qualification using actual period data, will be recouped from the hospital and redistributed to other DSH hospitals in accordance with subparagraph (1) above.

b. Governmental DSH providers shall receive payments from a pool of funds in the total computable amount of twenty-five dollars (\$25.00).

1. The distribution of funds from the pool shall be on the basis of each qualifying hospital's uncompensated care cost (as defined in paragraph A-4 above).

2. The federal share of the DSH payments to governmental hospitals under this paragraph b., when combined with the federal share of the DSH payment made to DSH hospitals under paragraph 3.a., shall not exceed the federal share of Hawaii's annual DSH allotment for each respective fiscal year, per Section 1923(f) of the Social Security Act.

4. No payment will be made to any hospital in excess of its total inpatient and outpatient hospital uncompensated care costs.

C. PAYMENT METHOD

Payments will be made in up to four installments for each DSH state plan rate year.

DSH payments for governmental DSH providers will be reconciled in accordance with the methodology set forth in the Protocol referred to in Section E.

D. SOURCE OF DATA

The calculations to be made in determining the payment amounts in accordance with section B.1. above shall be based on cost reports for each hospital's most current fiscal year concluded by June 30, 2011 for DSH state plan rate year ending September 30, 2012. For all subsequent state plan rate years, the payment amount calculations in section B.3.a shall also follow the same timing (e.g., cost reports for each hospital's most current fiscal year concluded by June 30, 2012 for DSH state plan rate year ending September 30, 2013). The calculations to be made in determining the payment amounts in accordance with sections B.2. and B.3.b. above shall be based on sources as specified in the cost protocol in section E below.

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E. COST PROTOCOL

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This protocol directs the method that will be used to determine uncompensated care (UCC) payments to government-owned hospitals as allowed by this Section VIII (Disproportionate Share Payments).

Summary of Medicare Cost Report Worksheets

Expenditures will be determined according to costs reported on the hospitals' 2552 Medicare cost reports as follows:

Worksheet A

The hospital's trial balance of total expenditures, by cost center. The primary groupings of cost centers are:

- (i) overhead;
- (ii) routine;
- (iii) ancillary;
- (iv) outpatient;
- (v) other reimbursable; and
- (vi) non-reimbursable.

Worksheet A also includes A-6 reclassifications (moving cost from one cost center to another) and A-8 adjustments (which can be increasing or decreasing adjustments to cost centers). Reclassifications and adjustments are made in accordance with Medicare reimbursement principles.

Worksheet B

Allocates overhead (originally identified as General Services Cost Centers, lines 1-24 of Worksheet A) to all other cost centers, including the non-reimbursable costs identified in lines 96 through 100.

Worksheet C

Computation of the cost-to-charge ratio for each cost center. The total cost for each cost center is derived from Worksheet B, after the overhead allocation. The total charge for each cost center is determined from the hospitals records. The cost to charge ratios are used in the Worksheet D series to determine program costs.

The governmentally operated hospitals (hospital) will utilize the Medicare cost report to determine uncompensated care costs described in the subsequent instructions. The above Medicare cost-to-charge ratio will be applied to the uncompensated care population program charges to determine cost. The cost will be reduced by actual payments received to determine the hospital's uncompensated care cost. Any DSH payments to hospitals by the

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State related to this DSH computation will not be reflected in the payment received to determine hospitals' uncompensated care cost. Non-Medicaid payments, funding and subsidies made by a state or unit of local government shall not be offset (e.g. state-only, local-only, or state-local health programs).

Notes:

For the purpose of utilizing the Medicare cost report to determine uncompensated care costs described in the subsequent instructions, the following terms and methodology are defined as follows:

The term "filed Medicare cost report" refers to the cost report that is submitted by the hospital to Medicare Fiscal Intermediary and is due five months after the end of the hospitals fiscal year end period.

The term "finalized Medicare cost report" refers to the cost report that is settled by the Medicare Fiscal Intermediary with the issuance of Notice of Program Reimbursement (NPR).

The "Uncompensated care costs (UCC)" includes covered inpatient and outpatient hospital services cost from the Medicaid Fee For Service (Medicaid FFS), QUEST Integration (QI) [~~Expanded (QEx)~~], and Uninsured population, less payments received from Medicaid FFS, (QI) [~~QEx~~], and uninsured patients.

Nothing in this document shall be construed to eliminate or otherwise limit a hospital's right to pursue all administrative and judicial review available under the Medicare program. Any revision to the finalized Audit Report as a result of appeals reopening, or reconsideration shall be incorporated into the final determination.

Determination of Allowable Payment to cover Uncompensated Care Costs (UCC)

To determine governmentally operated hospital's (hospital) allowable UCC, the following steps must be taken to ensure Federal financial participation (FFP):

Annual Payment

Each hospital's annual DSH payments will be based on its filed Medicare cost reports for the spending year to which the payments apply or, if not available, for the most recent year for which a report is available. If a prior year cost report is used for the interim payment purposes, the annual payment will be determined as described below but using the data from that prior period, and such interim payment will then be first reconciled to the annual payment computed from the spending cost reporting period, as described below, once that spending year Medicare cost report is filed by the hospital.

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| TN No. | <u>10-004</u> | | 10/01/2021 <u>[06/30/2010]</u> |
| | [09-002] | 43c | |

The annual payment is based on the calculation of inpatient and outpatient program costs using the cost center per diems and cost-to-charge ratios derived from its filed Medicare cost report for the service period. Days, charges, and payments for Medicaid FFS services originating from the provider's auditable records will be reconciled to MMIS paid claims records. Medicaid managed care and uninsured days, charges, and payments will originate from the provider's auditable records.

For each inpatient hospital routine cost center, a per diem is calculated by dividing total costs of the cost center (from ws B, part I, column 25) by total days of the cost center (from ws S-3, Part I, column 6). For each ancillary hospital cost center, a cost to charge ratio is calculated by dividing the total cost of the cost center (from ws B, Part I, column 25) by the total charges of the cost center (from ws C, Part I, column 8). The Adult and Pediatric (A&P) routine per diem, in accordance with CMS 2552 worksheet D-1, should be computed by including observation bed days in the total A&P patient day count and excluding swing bed nursing facility costs and non-medically necessary private from differential cost from the A&P costs.

For inpatient UCC cost computation, each routine hospital cost center's per diem is multiplied by the cost center's number of eligible UCC days, and each ancillary hospital cost center's cost-to-charge ratio is multiplied by the cost center's UCC-eligible inpatient charges. Eligible UCC days and charges pertain only to the UCC populations and services and exclude any non-hospital services such as physician/practitioner professional services. The sum of each cost center's inpatient hospital UCC cost is the hospital's inpatient UCC cost prior to the application of payment/revenue offsets.

For outpatient UCC cost computation, each ancillary hospital cost center's cost-to-charge ratio is multiplied by the cost center's UCC-eligible outpatient charges. Eligible UCC charges pertain only to the UCC populations and services as defined in the STCs and exclude any non-hospital services such as physician/practitioner professional services. The sum of each cost center's outpatient hospital UCC cost is the hospital's outpatient UCC cost prior to the application of payment/revenue offsets.

The cost computed above will be offset by all applicable payments received for the Medicaid and uninsured services included in the UCC computation and then reconciled to the interim quarterly UCC payments made.

Payments that are made independent of the claims processing system for hospital services of which the cost are included in the program costs described above, including payments from managed care entities, for serving QUEST Integration (QI) ~~[QI]~~ enrollees, will be included in the total program payments under this annual initial reconciliation process. Non-Medicaid payments, funding and subsidies made by a state or unit of local government will not be included in the total program payment offset.

Final Reconciliation Payment

Each hospital's annual DHS payment in a spending year will also be subsequently reconciled to its finalized Medicare cost report for the respective cost reporting period. The hospital will adjust, as necessary, the aggregate amount of UCC reported under the final reconciliation payment.

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| TN No. | <u>09-002</u> | Date: 43d | | [09/27/13] |
| | [08-016] | | | |

If, at the end of the final reconciliation process, it is determined that expenditures claimed were overstated or understated, such overpayment or underpayment will be properly reported to the federal government. The same methodology detailed in the annual payment will be used for the final reconciliation payment. The final reconciliation payments are based on the recalculation of program costs using the cost center's per diem and cost-to-charge ratios from the finalized Medicare cost report for the services period. The hospital will update the program charges to include only paid claims from Medicaid FFS and QUEST Integration (QI) [~~QE~~] in computing program cost for the reporting period. For the uninsured population, the hospital will update any payment made by or on behalf of the uninsured. Days, charges, and payments for Medicaid FFS originating from the provider's auditable records will be reconciled to MMIS paid claims records. Medicaid managed care and uninsured days, charges, and payment will originate from the providers auditable records. The hospital will report inpatient and outpatient UCC based on program data related to medical services that are eligible for Federal financial participation for the uncompensated care costs under this DSH process.

The inpatient and outpatient costs computed above will be offset by all applicable payments received for the Medicaid and uninsured services included in the UCC computation and then reconciled to the interim DSH payments.

Payment that are made independent of the claims processing system for hospital services of which the costs are included in the program costs described above, must be included in the total program payments under this final reconciliation process. Non-Medicaid payments, findings, and subsidies made by a state or unit of local government shall not be offset. Federal matching funds may be claimed for UCCs up to the hospitals' eligible uncompensated costs as determined in this process.

The final reconciliation described above will be performed and completed within six months after the issuance of all of the finalized government-owned hospital Medicare cost reports from each respective fiscal year. The State is responsible to ensure the accuracy of DSH amounts used for federal claiming.

If a hospital financial and cost reporting period does not coincide with the Medicaid State plan period for which the DSH UCC cost is being computed, the hospital's cost will be the computed based on its full cost reporting period, as prescribed above, and then allocated pro rate to a State plan period based on the number of months covered by the financial or cost reporting period that are included in the Medicaid State plan period.

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