Enclosure 3

Attachment 4.19 A

- The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

Approval Date _____
Effective Date _____

Plan # _____
Supersedes Plan # _____

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF ALABAMA

METHOD FOR PAYMENT OF REASONABLE COSTS INPATIENT HOSPITAL SERVICES

I. GENERAL PRINCIPLES

Effective Date: 01/01/02

Inpatient reimbursement rates, including payment for psychiatric services for individuals under 21 and over 65 years of age, and for psychiatric residential treatment services for individuals under age 21, are calculated from cost reports filed in accordance with this plan. The rates will be the lesser of each facility's reasonable costs per day as determined by the method as outlined herein. Payment for transplant service is exempt from Sections I-VIII of this Plan (see Section XX).

II. DEFINITIONS

(a) Cost Report: A report which details, for purposes of Medicaid reimbursement, the cost of rendering covered services for the fiscal reporting period. The Medicaid Uniform Cost Report contains the forms utilized in filing said cost report.

(b) Accrual Method of Accounting: For Medicaid cost reporting purposes, an allocating of revenues and expenses to the accounting period in which they are incurred. This must be done regardless of when cash is received or disbursed.

(c) Allowable Costs: Costs of services incurred by an efficiently and economically operated hospital which are not otherwise disallowed by the reimbursement principles established in Chapter 23 Hospital Reimbursement Program of the Alabama Medicaid Agency Administrative Code. These principles are a set of rules, regulations, laws, and interpretations which provide direction as to the allowability of costs incurred by hospitals for the inclusion of these costs in their prospective Medicaid inpatient reimbursement rates. These rules, regulations, laws, and interpretations are promulgated by the Alabama Medicaid Agency, and are, in part, based on generally accepted accounting principles and regulations required of the Alabama Medicaid Program by various federal and state laws and regulations.

(d) Reasonable Costs: Necessary and ordinary costs related to patient care which a prudent and cost-conscious hospital would pay for a given item or service.

(e) Educational Costs: Reasonable costs of approved educational programs of study which have been certified by an appropriate federal, state, or other regulatory body.

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(f) Costs Related to Capital Assets: For purposes of this plan, capital cost shall consist of the following:

1. Depreciation -
   Building and Fixed Equipment
   Major Moveable Equipment

2. Interest -
   Working Capital

(g) Low Occupancy Adjustment: An adjustment to be computed for those hospitals which fail to maintain the minimum level of occupancy of the total licensed beds. A 70% occupancy factor will apply to hospitals with 100 or fewer beds. An 80% occupancy factor will apply to hospitals with 101 or more beds. Such adjustment will be composed of the fixed cost associated with the excess unoccupied beds and shall be a reduction to Medicaid inpatient cost.

(h) Trend Factors: A statistical measure of the change in costs of goods and services purchased by a hospital during the course of one year. The trend factors to be used for purposes of this plan shall be computed based upon the economic indicators as published by Data Resources, Inc. (DRI).

(i) Patient Day: Any day that a bed is either occupied or reserved for a patient on an authorized and temporary leave of absence from the hospital. The midnight to midnight method must be used for Medicaid reporting purposes.

(j) Approved Capital Expenditure Project: A project for which a Certificate of Need has been issued by the State Health Planning Agency. Such a project may include expansions, renovations, and/or additions to an existing facility. Acquisition of an ongoing facility is not considered an approved capital expenditure project for purposes of revising per diem rates.

Medicaid reserves the right to decline reimbursement of depreciation and interest expense related to asset purchases not previously approved by Medicaid. In addition, Medicaid will not reimburse costs related to new patient care beds which would add to the licensed bed capacity constructed under certificates of need dated on or after October 1, 1983. With respect to replacement beds placed into service on or after October 1, 1983, the hospital must request, in advance of a Medicaid contract application, a determination from Medicaid as to whether the

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depreciation, interest, and other capital-related costs of the beds may be included in allowable Medicaid cost. Such replacement beds must have a CON dated prior to October 1, 1983 for actual capital costs to be considered by Medicaid. In those situations regarding replacement bed construction under CONs dated after October 1, 1983, the Agency will continue to recognize allowable capital costs related to the assets before replacement construction. Replacement of equipment is not affected by this limitation.

Effective Date: 01/01/92

(k) Return on Equity Capital (applicable to proprietary hospitals only): An allowance to proprietary hospitals which is based upon a reasonable return on the invested equity capital related to the provision of necessary patient care. Such allowance shall be eliminated over a three year period. Beginning with the 7/1/88 rate period, payment will be 75% of the amount as normally calculated; 7/1/89, 50%; 7/1/90, 25%, and zero thereafter.

(l) Hospital Group: There are four groups of hospitals for Medicaid rate calculation purposes. The groups are as follows:

(1) Urban: Hospitals located within a Metropolitan Statistical Area (MSA) or the successor of such MSA as defined by the U. S. Bureau of Census.

Effective Date: 07/01/94

(a) Grouped According to Bed Size

0 - 100 licensed beds	Urban 1
101 - 250 licensed beds	Urban 2
251 - 500 licensed beds	Urban 3
501 + licensed beds	Urban 4

(2) Rural: Hospitals not located within an MSA or successor to an MSA.

(3) Unique or Specialized: Hospitals which provide unique or specialized services atypical to any group. Such classification shall be at the discretion of Medicaid. The criteria used by the Division of Licensure and Certification of the Alabama Health Department in licensing a hospital shall be considered by the Alabama Medicaid Agency in determining which hospitals should be classified as unique or specialized.

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(m) Access Payment: A supplemental 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, 2013, through September 30, 2020, 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 per diem, supplemental and DSH payments, 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, Chapter 51 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 defined as a Long Term Acute Care Hospital 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, supplemental payments and DSH payments, 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 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, 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.

(s) Rehab Hospitals and Long Term Acute care hospitals referenced in paragraph (p) (4) and (p)(5) above are not included in UPL or reimbursed by Medicaid for base payments, access payments under section 4.19-A.

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(4) Psychiatric hospitals: Psychiatric hospitals which are enrolled with Medicaid to provide inpatient psychiatric services to children under 21 years old and to adults who are over 65 years of age.

Effective Date: 01/01/92

III. PER DIEM RATE COMPUTATION

(a) The as-filed Medicaid FY cost report will be used to compute a hospital's per diem rate. The cost report shall be desk reviewed and any non reimbursable items will be removed from reported cost prior to calculating a rate.

(b) The per diem rates as calculated by the Alabama Medicaid Agency shall be provided to the hospitals prior to the effective date for their information and review.

(c) The total Medicaid cost from the cost report shall be adjusted as follows:

(1) The medical education cost per diem and the capital-related cost per diem are subtracted from the inpatient hospital cost per diem. The remaining cost per diem is separated into Administrative and General (A & G) and non- Administrative and General per diem components. The components will then be multiplied by the applicable hospital industry trend factor (as adjusted by any relevant trend factor variance). The resulting trended A & G cost per diem will be arrayed within hospital grouping in ascending order. The number of hospitals in each grouping will be multiplied by the applicable percentile to determine the position of the hospital that represents the appropriate percentile. That hospital's cost in each grouping will become the ceiling for that grouping. The ceiling or actual cost per day (whichever is less) will be the adjusted Administrative and General per diem cost. Add the adjusted (if applicable) A & G per diem component cost to the non-administrative per diem component cost.

(2) Capital-Related and Medical Education Costs Per Diem

(A) Adjust capital-related cost for all hospitals per diem be any applicable low occupancy cost per day. (Rural hospitals shall not be subject to a low occupancy adjustment.)

(B) Medical Education cost per diem will be multiplied by the hospital industry medical education costs trend factor.

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(3) The total Medicaid per diem cost per day, subject to the overall applicable percentile ceiling, shall consist of:

(A) Operating costs as adjusted in III(c)(1) above.

(B) Capital-related cost as determined in III(c)(2) above.

(C) Return on Equity per day, if applicable (for proprietary hospitals). Beginning with the 7/1/88 rate period, payment will be 75% of the amount as normally calculated; 7/1/89, 50%; 7/1/90, 25%, and zero thereafter.

Effective Date: 07/01/94

(4) The total Medicaid costs per day as determined in III.(c)(3) shall be separated into the applicable hospital groupings. Within the grouping, the total cost per day will be arrayed in ascending order. The number of hospitals in each grouping will be multiplied by the applicable percentile to determine the position of the hospital that represents the appropriate percentile. That hospital's cost in each grouping will be the ceiling for that grouping. Hospitals determined to be unique or rural by the Agency are not subject to these ceilings. Urban I hospitals shall be subject to a 90th percentile ceiling. Urban II, III, and IV hospitals shall be subject to an 80th percentile ceiling. Psychiatric hospitals shall be subject to a 60th percentile ceiling.

(5) The lesser of the above-determined ceiling or actual cost per day shall be added to any applicable education cost as adjusted in III(c)(2)(B). The sum shall be a hospital's Medicaid per diem rate for the new period.

(d) The projected trend factor shall be computed on an annual basis and applied to those costs subject to the factor from the mid-point of the hospital's cost report period to the mid-point of the rate period. Adjustments to the trend factor (trend factor variances) shall be calculated as follows:

(1) Adjustments shall be made only for variations from the projected to the actual of greater than one-half of one percent in either direction.

(2) These adjustments shall be made on a prospective basis and shall become a part of the trend factor for the current rate period.

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(e) Adjustments to Rates: The prospectively determined individual hospital's reimbursement rate may be adjusted as deemed necessary by the Agency. Circumstances which may warrant an adjustment include, but are not limited, to:

(1) A previously submitted and/or settled cost report is corrected. If an increase or decrease in rate results, any retroactive adjustments shall be applied as of the effective date of the original rate. Any such payment or recoupment will be made in the form of a lump sum amount and/or a rate change.

(2) The information contained in the cost report is found to be intentionally misrepresented. Such adjustment shall be made retroactive to the date of the original rate. This may be considered grounds to suspend the hospital from participation in the Alabama Medicaid Program.

(3) The hospital experiences extraordinary circumstances which may include, but are not limited to, an Act of God, war, or civil disturbance. Adjustments to reimbursement rates may be made in these and related circumstances.

(4) Under no circumstances shall adjustments resulting from paragraphs (1)-(3) above exceed the group ceiling established. However, if adjustments as specified in (1) through (3) so warrant, Medicaid may recompute the group ceiling.

Effective Date: 10/01/95

(f) Prepaid Health Plan (PHP):

(1) As an alternative to paying a per diem rate to each hospital for inpatient services; hospitals, except for psychiatric hospitals which will continue to be paid fee-for-service, in contiguous counties in a geographical area will form an organization or entity, i.e., a Prepaid Health Plan (PHP) prior to October 1, 1995. The incentive for hospitals to participate in the PHP is the same as other capitation payment systems. The hospitals can eliminate duplica-tion of services and coordinate care. They benefit by cutting costs and coming in under the capitation rate. The PHP would contract with the Alabama Medicaid Agency to provide inpatient hospital services to Medicaid eligibles residing in the PHP's geographic area under a capitated payment arrangement. The PHP will be activated according to the beginning date on its signed contract. The contract between Medicaid and the PHP will require that the PHP pay all hospitals the cost on an efficiently and

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economically operated level. Medicaid patients do not lose freedom of choice; however, the networks should structure services to encourage patients to stay within the network. If a patient goes to a hospital outside the network, the network in which the patient resides will pay for the inpatient services. The payment rate would be as described in Section III, pages 4-6 of attachment 4.19-A which will still be calculated by the Alabama Medicaid Agency for all hospitals in the Medicaid Program. Claims for inpatient services will be processed by the Alabama Medicaid Agency and they will generate zero paid Explanation of Payments to the network so they can make payment to the individual hospitals. The PHP will be required to pay rates to all in-state hospitals using identical methodology for hospitals in or out of the PHP. The claims for inpatient services would continue to be processed through the Alabama Medicaid Agency programs for any benefit limitations and for gathering of Medicaid statistical data. The disproportionate share payments for the hospitals in the PHP would be added to the capitated payments.

(2) Capitation Rate Methodology:

(a) The capitated rate would be as follows:

$$\frac{\text{Historical Cost (2)(b)(1)}}{\text{Eligible Months (2)(b)(2)}} = \text{Payment Per Member Per Month}$$

(b) The capitation rate methodology will be as follows:

1. The Alabama Medicaid Agency historical inpatient hospital costs will be obtained from Alabama Medicaid paid claims listing for all of the participating hospitals in each geographic PHP. The base period will be July 1, 1993, through June 30, 1994. Base period cost will be trended to current year based upon the economic indicators as published in Health Care Costs by DRI/McGraw-Hill as is the current methodology.

2. Eligible months is defined as the total number of months Medicaid only recipients were certified for Alabama Medicaid eligibility for the base period of July 1, 1993, through June 30, 1994, which will be updated annually, excluding SOBRA adults in maternity waiver counties and Part A Medicare eligibles.

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(3) Disproportionate share hospitals payment: The sum of the disproportionate share payments that would be payable to the individual hospitals that are members of the PHP, not to exceed the amount allowed under OBRA '93.

(4) Payments:

(a) The PHP would receive a monthly capitated payment for each eligible, plus the PHP disproportionate share payment.

(b) Alabama Medicaid shall not pay a PHP more for inpatient hospital services under a capitation rate than the cost of providing those services under the regular inpatient hospital payment methodology.

(c) Capitation payments to the plan for all eligible enrollees shall be made monthly. The PHP will receive the monthly capitated payment for each member regardless of utilization of PHP inpatient hospital services as indicated in the capitation rate methodology. The capitation rates are determined using historical costs and historical utilization. They do not exceed Medicare upper limits; therefore, the capitation payments should not exceed Medicare upper limits.

(d) Payments described in Section III,(h), pages 6C and 6D of Attachment 4.19-A will be paid directly to the appropriate hospitals as defined in Section III (h).

(5) Should Medicaid not contract with a PHP, Medicaid will continue paying those hospitals that are not members of a PHP using present per diem methodology on a fee for service basis.

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(g) Inpatient and outpatient retroactive settlements on amended Medicare/Medicaid cost reports with fiscal years ending prior to October 1, 1984, will no longer be processed for payment by or to the Alabama Medicaid Agency.

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Effective Date: 11/01/95

(h) As an alternative, for the period October 1, 1995 through September 30, 1996, each hospital shall receive a per diem payment and a disproportionate share payment. The sum of such payments, at each hospital, shall not exceed:

HOS0001H	SOUTHEAST ALABAMA M.C.	13,013,079
HOS0004H	NORTH JACKSON HOSPITAL	1,065,770
HOS0005H	BOAZ - ALBERTVILLE M.	4,947,408
HOS0006H	ELIZA COFFEE MEMORIAL	10,650,074
HOS0007H	MIZELL MEMORIAL HOSPITAL	539,571
HOS0008H	CRENSHAW BAPTIST HOSPITAL	1,087,039
HOS0009H	HARTSELLE MEDICAL CENTER	136,495
HOS0010H	GUNTERSVILLE - ARAB M.C.	2,143,710
HOS0011H	MEDICAL CENTER EAST	1,773,877
HOS0012H	DEKALB BAPTIST M.C.	1,698,462
HOS0015H	THOMASVILLE HOSPITAL	234,530
HOS0016H	SHELBY MEDICAL CENTER	9,029,201
HOS0018H	EYE FOUNDATION HOSPITAL	248,643
HOS0019H	HELEN KELLER MEMORIAL	5,123,285
HOS0021H	DALE MEDICAL CENTER	6,655,628
HOS0022H	CHEROKEE BAPTIST M.C.	294,786
HOS0023H	BAPTIST - MONTGOMERY	8,738,761
HOS0024H	JACKSON HOSPITAL & CLINIC	4,004,927
HOS0025H	GEORGE H. LANIER MEMORIAL	1,568,431
HOS0027H	ELBA GENERAL HOSPITAL	825,713
HOS0029H	EAST ALABAMA M.C.	22,353,389
HOS0031H	PHENIX MEDICAL PARK	1,469,186
HOS0032H	WEDOWEE HOSPITAL	597,892
HOS0033H	U.A.B. HOSPITALS	73,273,587
HOS0034H	COMMUNITY - TALLASSEE	656,121
HOS0035H	CULLMAN MEDICAL CENTER	6,184,463
HOS0036H	ANDALUSIA HOSPITAL	1,308,425
HOS0038H	STRINGFELLOW MEMORIAL HOSPITAL	400,307
HOS0039H	HUNTSVILLE HOSPITAL	29,602,810
HOS0040H	GADSDEN REGIONAL	3,604,697
HOS0043H	VAUGHAN CHILTON M.C.	117,936
HOS0044H	MARION BAPTIST M.C.	234,027
HOS0045H	FAYETTE COUNTY HOSPITAL	622,421
HOS0046H	RIVERVIEW REGIONAL MEDICAL CENTER	1,980,781
HOS0047H	GEORGIANA DOCTORS HOSPITAL	155,188
HOS0049H	MEDICAL CENTER ENTERPRISE	2,039,820
HOS0050H	BLOUNT MEMORIAL	450,599
HOS0051H	GREENE COUNTY	511,313
HOS0052H	LAKESHORE COMMUNITY HOSPITAL	292,782
HOS0053H	ATMORE COMMUNITY HOSPITAL	594,029
HOS0054H	PARKWAY MEDICAL CENTER	435,730
HOS0055H	FLOWERS HOSPITAL	1,755,044

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HOS0056H	ST VICENT'S HOSPITAL	3,066,286
HOS0058H	BIBB MEDICAL CENTER	1,377,532
HOS0059H	LAWRENCE BAPTIST M.C.	545,934
HOS0061H	JACKSON COUNTY HOSPITAL	4,328,312
HOS0062H	WIREGRASS HOSPITAL	2,159,593
HOS0064H	CARRAWAY METHODIST MEDICAL CENTER	7,223,790
HOS0065H	RUSSELL HOSPITAL	1,289,396
HOS0066H	FLORALA MEMORIAL HOSPITAL	63,152
HOS0068H	LLOYD NOLAND HOSPITAL	1,714,909
HOS0069H	LAKEVIEW COMMUNITY HOSPITAL	521,658
HOS0072H	COOSA VALLEY MEDICAL CENTER	2,531,928
HOS0073H	CLAY COUNTY HOSPITAL	2,060,600
HOS0078H	NORTHEAST ALABAMA R.M.C.	17,532,099
HOS0079H	ATHENS - LIMESTONE HOSPITAL	5,096,145
HOS0080H	LAMAR REGIONAL HOSPITAL	19,162
HOS0081H	MONTGOMERY REGIONAL	4,008,005
HOS0083H	SOUTH BALDWIN HOSPITAL	2,556,728
HOS0084H	HEALTHSOUTH MEDICAL CENTER	585,477
HOS0085H	DECATUR GENERAL HOSPITAL	10,928,708
HOS0086H	CARRAWAY NORTHWEST M.C.	399,146
HOS0087H	UNIVERSITY SOUTH ALABAMA M.C.	51,880,412
HOS0089H	WALKER BAPTIST M.C.	3,588,039
HOS0090H	PROVIDENCE HOSPITAL	1,851,759
HOS0091H	GROVE HILL MEMORIAL	824,702
HOS0092H	DCH REGIONAL MEDICAL CENTER	31,894,328
HOS0094H	NORTHWEST MEDICAL CENTER	787,522
HOS0095H	HALE COUNTY HOSPITAL	243,982
HOS0097H	ELMORE COMMUNITY HOSPITAL	2,125,262
HOS0098H	RANDOLPH COUNTY HOSPITAL	771,568
HOS0099H	D.W. McMILLAN MEMORIAL	1,124,136
HOS0100H	THOMAS HOSPITAL	1,916,327
HOS0101H	CITIZEN'S BAPTIST M.C.	2,986,471
HOS0102H	J. PAUL JONES HOSPITAL	646,098
HOS0103H	BIRMINGHAM BAPTIST PRINCETON	3,453,058
HOS0104H	BIRMINGHAM BAPTIST MONTCLAIR	3,856,918
HOS0108H	AUTAUGA MEDICAL CENTER	185,899
HOS0109H	PICKENS COUNTY HOSPITAL	1,089,397
HOS0110H	BULLOCK COUNTY HOSPITAL	880,250
HOS0112H	BRYAN W. WHITFIELD MEMORIAL	6,727,453
HOS0113H	MOBILE INFIRMARY MEDICAL CENTER	3,837,601
HOS0114H	BESSEMER CARRAWAY	1,915,008
HOS0115H	RED BAY HOSPITAL	342,429
HOS0117H	THE MEDICAL CENTER	-
HOS0118H	FOUR RIVERS MEDICAL CENTER	1,978,916
HOS0119H	USA DOCTORS HOSPITAL	17,406,320
HOS0120H	MONROE COUNTY HOSPITAL	3,269,540
HOS0121H	VAUGHAN REGIONAL M.C.	3,893,213

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HOS0123H	FLORENCE HOSPITAL	297,885
HOS0124H	MEDICAL CENTER SHOALS	305,529
HOS0125H	BURDICK WEST MEMORIAL	581,216
HOS0126H	EDGE REGIONAL M.C.	1,619,368
HOS0127H	HUNTSVILLE HOSPITAL EAST	750,230
HOS0128H	VAUGHAN JACKSON M.C.	469,386
HOS0129H	NORTH BALDWIN HOSPITAL	2,235,013
HOS0130H	ST. CLAIR REGIONAL HOSPITAL	917,408
HOS0131H	CRESTWOOD HOSPITAL	269,894
HOS0134H	WASHINGTON COUNTY INFIRMARY	263,832
HOS0137H	COOPER GREEN HOSPITAL	74,518,403
HOS0138H	HILL HOSPITAL SUMTER COUNTY	317,173
HOS0139H	AMI BROOKWOOD MEDICAL CENTER	3,505,147
HOS0143H	WOODLAND COMMUNITY HOSPITAL	913,266
HOS0144H	SPRINGHILL MEMORIAL HOSPITAL	731,749
HOS0145H	NORTHPORT HOSPITAL - DCH	2,840,534
HOS0146H	JACKSONVILLE HOSPITAL	1,785,391
HOS0148H	VAUGHAN EVERGREEN M.C.	768,997
HOS0149H	EAST MONTGOMERY MEDICAL CENTER	1,942,119
HOS0150H	L.V. STABLER MEMORIAL	704,583
HOS0152H	USA KNOLLWOOD PARK HOSPITAL	5,043,193
HOS0155H	VAUGHAN PERRY HOSPITAL	192,478
HOS3025H	LAKESHORE HOSPITAL	129,972
HOS3300H	CHILDREN'S HOSPITAL	56,438,529

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(h) Publicly owned acute care hospitals will be paid an enhanced payment not to exceed Medicare upper limits in the aggregate. The rate will be determined by the following methodology:

(1) Publicly owned acute care hospitals in urban groupings (as indicated in 4.19-A, II (l)(1)(a), page 3) will be paid an amount above any applicable ceilings up to their computed cost, multiplied by Medicaid paid days.

(2) All publicly owned acute care hospitals will be paid an amount determined by: the computed per diem cost multiplied by a percentage determined by the Alabama Medicaid Agency for Medicaid paid days (including Health Maintenance Organization (HMO) and Maternity Waiver days).

(3) All public hospitals will receive an enhanced payment consisting of two tiers for public urban hospitals and one tier for public rural hospitals. The first tier will be to reinstate amounts lost due to the low occupancy adjustment (LOA) and the class ceilings, both administrative and general (A & G) and overall.

EXAMPLE OF FIRST TIER

Hospital A had an LOA of $50 per day, A & G of $100 per day with a class ceiling of $95 per day, an overall per diem rate of $700 per day with a class ceiling of $650 per day. Their enhanced payment would be:

LOA	$50
A & G ceiling difference ($100 - $95)	$5
Overall ceiling difference ($700 - $650)	$50
Total Enhancement	$105

Hospital B had an LOA of $40 per day, A & G of $90 per day with a class ceiling of $95 per day, an overall per diem rate of $652 per day with a class ceiling of $650 per day. Their enhanced payment would be:

LOA	$40
A & G ceiling difference ($90 - $95)	$0
Overall ceiling difference ($652 - $650)	$2
Total Enhancement	$42

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SECOND TIER

The second tier will be an amount added to each public hospital's per diem rate. This amount will represent a portion of a pool calculated using the Medicare upper payment limit theory, less amounts reimbursed to the public urban hospitals under the first tier explained above.

The total pool will be calculated using the public hospital's total inpatient revenue, less any SNF and non-covered revenues, divided by total revenues, to determine percentage A.

Percentage A will then be multiplied by total expenses, less any SNF and non-covered expenses, to arrive at allowable inpatient costs (AIC).

AIC will then be divided by total adult and boarder inpatient days (days incurred by newborn when mother has been discharged) to determine Medicare costs per day (MCPD).

MCPD will then be multiplied by paid Medicaid days to determine what Medicaid would have paid using Medicare principles.

Paid Medicaid days will then be multiplied by the Medicaid per diem rate (effective July 1 of the current rate year) to determine what Medicaid paid. The aggregate payments using Medicare principles would then be compared to the amount Medicaid paid to determine the upper limit.

The amount determined to be paid under the first tier will then be subtracted from this Medicare upper limit pool. The remainder will be divided by the total estimated Medicaid payments to arrive at the percentage add-on each public hospital would receive.

The Maternity and HMO days are not included in the calculation of the upper payment limit pool. Maternity and HMO days will be included in the enhanced payment calculation, since they are paid Medicaid days and the rates increase when the per diem rates are increased.

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(i) Acute care hospitals in the unique or specialized hospital group (as defined under paragraph II(I)(3) of this State Plan) whose inpatients are predominantly under 18 years of age will be paid an enhanced payment. The rate will be the Medicaid computed per diem rate multiplied by thirty percent for all paid Medicaid days.

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(j) For the period October 1, 2017, through September 30, 2020, 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 year 2020 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 year 2020.

Effective October 1, 2018, Long Acting Reversible Contraceptives (LARCs) will be reimbursed separately from the inpatient daily per diem rate when the LARC is provided as part of the inpatient obstetrical delivery or in the outpatient setting immediately after discharge. A separate outpatient claim may be submitted by the hospital for reimbursement under the appropriate HCPCS code when the LARC is provided in the inpatient setting immediately after delivery.

(2) Base (per diem) payments for state fiscal year 2020 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) Quarterly access payments as outlined in paragraph (k) and (l) on pages 6I through 6I.5 will be distributed as follows:

a. State owned and operated hospitals' inpatient access payments will be distributed first by removing any negative Upper Payment Limit Gap, reallocate any access to ensure the state owned mental health facility does not exceed OBRA payments, reallocate $24,973,243 and $53,514,092 to be paid to rural and children hospitals, respectively, in proportion to all rural and children hospitals total upper payment limit and finally reduce any access payments to ensure a payment over billed amount is not made. All remaining access will be allocated based on the hospitals Upper Payment Limit Gap in relation to the total Upper Payment Limit Gap.

b. Non state government owned or operated hospitals' inpatient access payments will be distributed first by removing any negative Upper Payment Limit Gap then reduce any access payments to ensure a payment over billed amount is not made and reallocate $24,973,243 and $53,514,092 to be paid to rural and children hospitals, respectively, in proportion to all rural and children hospitals total upper payment limit. All remaining access will be allocated based on the hospitals Upper Payment Limit Gap in relation to the total Upper Payment Limit Gap.

c. Privately owned and operated hospitals' inpatient access payments will be distributed first by paying free standing psychiatric hospitals per paragraph (n) on page 6J, then removing any negative Upper Payment Limit Gap, reallocating $24,973,243 and $53,514,092 to be paid to rural and children hospitals, respectively, in proportion to all rural and children hospitals total upper payment limit, and finally reduce any access payments to ensure a payment over billed amount is not made. All remaining access payments will be allocated based on the hospitals Upper Payment Limit Gap in relation to the total Upper Payment Limit Gap. During the period October 1, 2019 through September 30, 2020, Inpatient Access payments to Children's Hospital of Birmingham, Alabama shall be limited to an amount that when added to estimated base payments equals 93% of estimated cost of inpatient services to Medicaid beneficiaries. Any UPL Gap that is not paid to providers including Childrens of Alabama through access payments will be allocated to a separate pool that will be paid in a subsequent period in proportion to the hospital that generated the pool.

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(k) For the period October 1, 2018, through September 30, 2020, the amount available for inpatient hospital access payments for state owned or operated hospitals, Non state government owned or operated hospitals', and Privately owned and operated hospitals' that are published in the Medicare IPPS rule shall be calculated as follows:

(1) Medicaid claims obtained from the State's MMIS system for the state fiscal year that ended one year prior to the start of the demonstration year will be repriced using the 3M MS-DRG grouper in effect for that year. For example, the FY2020 UPL demonstration will use SFY2018 claims and the 3M MS-DRG grouper in effect for SFY2018. The equivalent Medicare payment from the 3M MS-DRG shall be the Upper Payment Limit.

(2) For state facilities and any childrens hospitals that are not published in the Medicare IPPS rule, A Medicare payment to charge ratio was determined from each cost report by obtaining the following information from the CMS Form 2552-10 cost reports for each hospital from the cost report that ended in the rate year one year prior to the beginning of the rate year:

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

1. Acute Care Services: Sum of Worksheet E Part A Lines 59, 68, 69, and 70.
2. Psych Hospitals: Sum of Worksheet E-3 Part II Lines 16, 27, 28, 29, and 30.
3. Children's Hospitals: Sum of Worksheet E-3 Part I 4, 15, and 17.
4. Critical Access Hospitals: Sum of Worksheet E-3 Part V Lines 5, 6, and 18.
5. Sub-provider Psych units: Sum of Worksheet E-3 Part II Lines 16, 27, 28, 29 and 30.
6. Sub-provider Rehab units: Sum of Worksheet E-3 Part III Lines 17, 28, 29, 30, and 31.

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

1. Acute Care Services: Sum of Worksheet D-3 Column 2 Lines 30-35, 43 and 200.
2. Psych Hospitals: Sum of Worksheet D-3 Column 2 Lines 40 and 200.
3. Children's Hospitals: Sum of Worksheet D-3 Column 2 Lines 30-35, 43 and 200.
4. Critical Access Hospitals: Sum of Worksheet D-3 Column 2 Lines 30-35, 43 and 200.
5. Sub-provider Psych units: Worksheet D-3 Column 2 Line 200 plus Worksheet D-1 Line 28 times the Medicaid utilization for the applicable sub-provider (Days per Worksheet S-3 Part I Line 17 Column 7 ÷ Worksheet S-3 Part I Line 17 Column 8).
6. Sub-provider Rehab units: Worksheet D-3 Column 2 Line 200 plus Worksheet D-1 Line 28 times the Medicaid utilization for the applicable sub-provider (Days per Worksheet S-3 Part I Line 17 Column 7 ÷ Worksheet S-3 Part I Line 17 Column 8).
7. Medicare organ acquisition charges (revenue code 081X Organ Acquisition) from Medicare Provider Statistical & Reimbursement (PS&R) Report obtained from provider.
8. Any additional Medicare charges related to organ acquisition billed to the Medicare Administrative Contractor, or otherwise.
9. Any additional charges related to denied encounter charges.

(3) The payment to charge ratio calculated in Step (2) will be multiplied by the Medicaid hospital charges obtained from the State's MMIS system for each hospital's discharges during the applicable cost report ended in the rate year one year prior to the beginning of the rate year for claims which would be covered during SFY 2020 to determine the amount Medicare would have paid for Medicaid services.

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(4) The amount determined in Step (1) and Step (3) will be multiplied by 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 separate utilization increase based on change in paid days a linear regression completed for the previous four State Fiscal Years and the fiscal year ended during the preceding cost reporting year and preceding rate year.

(5) The amount determined in this step will be the Upper Payment Limit amount set forth in 42 CFR 447.272. An aggregate Upper Payment Limit amount will be established for State owned and operated hospitals, Non state government owned or operated hospitals', and Privately owned and operated hospitals'.

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(6) The Medicaid allowed amount, for claims included in Step (3), was obtained from the MMIS for the same period as outlined in paragraphs (1) and (2). 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 the mid-point of the State Fiscal Year the cost reporting year ends during. The standardized Medicaid payments for State Fiscal Year ending in the cost reporting year were multiplied by the utilization increase and adjustment factor amount in Step (5) to determine the Medicaid payments for rate year and the preceding rate year.

(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 Gap amount for State owned and operated hospitals, Non state government owned or operated hospitals', and Privately owned and operated hospitals'. The Upper Payment Limit Gap will represent the maximum amount the State shall pay for Access payments to State owned and operated hospitals.

(l) For the period October 1, 2018, through September 30, 2020, the amount available for inpatient hospital access payments for privately owned and operated hospitals and non-state government owned and operated hospitals that are not childrens hospitals or included in the Medicare IPPS rule and have a UPL calculation determined from paragraph (5), for example Critical Access and freestanding IMD hospitals shall be calculated as follows:

(1) Data from hospital's CMS Form 2552-10 cost reports that ended in the rate year one year prior to the beginning of the rate year (ex. Cost reports ending in rate year 2017 for the rate year beginning October 1, 2018) will be used to determine the upper payment limit.

(2) A routine inpatient cost to charge ratio and an inpatient ancillary cost to charge ratio are determined from each cost report by obtaining the following information from the CMS Form 2552-10 cost reports for each hospital:

(a.) Inpatient routine cost to charge ratio

(i.) Total cost will be accumulated from Worksheet B Part I Column 24 for Lines 30-43.

(ii.) Total charges will be accumulated from Worksheet C Part I Column 6 for CMS Lines 30-43.

(iii.) Total cost per paragraph (i) will be divided by total charges per paragraph (ii) to determine the inpatient routine cost to charge ratio for each hospital.

(b.) Inpatient ancillary cost to charge ratio

(i.) Total cost for each of the following centers on Worksheet B Part I is obtained: CMS Lines 50-76.99 and 90-93.99.

(ii.) Inpatient charges for each of the following cost centers on Worksheet C Part I Column 6 are obtained: CMS Lines 50-76.99 and 90-93.99.

(iii.) Total charges for each of the following cost centers on Worksheet C Part I Column 8 are obtained: CMS Line 50-76.99 and 90-93.99.

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(iv.) Inpatient charges for each CMS Line in paragraph (ii) will be divided by the total charges for each CMS Line in paragraph (iii) to determine an inpatient percentage of charges.

(v.) The total cost for each CMS Line in paragraph (i) will be multiplied by the inpatient percentage of charges for each CMS Line in paragraph (iv) to determine the inpatient cost.

(vi.) Total inpatient cost determined in paragraph (v) will be divided by total inpatient charges from paragraph (ii) to determine an inpatient ancillary cost to charge ratio.

(c.) For privately owned and operated psych hospitals that do not file a Medicare cost report, the Medicaid submitted cost report will be used as follows:

(i.) Total inpatient cost Per Medicaid Worksheet C Column 2 Line 150 and Line 156 through Line 196.

(ii.) Total inpatient charges Per Medicaid Worksheet C Column 1 Line 150 and Line 156 through Line 196.

(iii.) Total inpatient cost to charge ratio will be paragraph (i) divided by paragraph (ii).

(3) Inpatient charges will be obtained from the State's MMIS system for each hospital's discharges during the applicable cost report ended in the rate year one year prior to the beginning of the rate year for claims which would be covered during SFY 2020. The inpatient charges will be obtained at the revenue code level.

(4) Inpatient charges for each hospital with revenue codes 001 through 219 will be multiplied by the inpatient routine cost to charge ratio determined in paragraph (2)(a)(iii) for each hospital to determine the inpatient routine cost.

(i.) For privately owned and operated psych hospitals that do not file a Medicare cost report, the MMIS inpatient charges will be multiplied by the cost to charge ratio in paragraph (c) to determine inpatient cost for privately owned and operated psych hospitals.

(5) Inpatient charges for each hospital with revenue codes 220 through 999 will be multiplied by the inpatient ancillary cost to charge ratio determined in paragraph (2)(b)(vi) for each hospital to determine the inpatient ancillary cost.

(6) Total inpatient Medicaid cost will be the total of paragraph (4) and (5). The total inpatient Medicaid cost will have the following amounts added:

(a.) The Medicaid cost will be increased by the Medicaid inpatient percentage of CRNA cost removed on Worksheet A-8 for each hospital. The Medicaid inpatient percentage is determined by dividing total Medicaid inpatient charges by total charges for the hospital.

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(7) The amount determined in paragraph (6) will be multiplied by 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 separate utilization increase based on change in paid days a linear regression completed for the previous four State Fiscal Years and the fiscal year ended during the preceding cost reporting year and preceding rate year. Both inflation and utilization will be applied from the mid-point of cost report year to the mid-point of rate year.

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(8) The Medicaid cost will be increased by the Medicaid inpatient percentage of the provider assessment paid by each hospital for the State Fiscal Year being calculated. The Medicaid inpatient percentage is determined by dividing total Medicaid inpatient charges from the cost report identified in paragraph (1) by total charges for the hospital from the cost report identified in paragraph (1).

The cost calculated in this paragraph will be the Upper Payment Limit amount set forth in 42 CFR 447.272 for privately owned and operated hospitals. An aggregate Upper Payment Limit amount will be established for each of the following hospital types: Privately owned and operated hospitals and Non-state governmental owned and operated hospitals.

(9) The Medicaid allowed amount for claims included in paragraph (3) was obtained from the MMIS to constitute the Medicaid payments for cost reporting periods ending in the rate year one year prior to the beginning of the rate year. The utilization increase identified in paragraph (7) and the cost report factors in paragraph (7) was applied to the Medicaid allowed amount to standardize all hospital payments to the mid-point of the State Fiscal Year including the ending date of the cost reporting year. The standardized Medicaid payments for State Fiscal Year ending in the cost reporting year were multiplied by the utilization increase amount and adjustment factor in paragraph (8) to determine the Medicaid payments for the rate year and the preceding rate year.

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(10) The difference between Medicare cost for Medicaid Services determined in paragraph (8) on page 6I.5 and the Medicaid payments in paragraph (9) on page 6I.5 for the rate year will be the Upper Payment Limit Gap that will be used as the limit to the amount of Access payments outlined in paragraph (m) and (n) below.

(m) For the period October 1, 2018, through September 30, 2020, in addition to any other funds paid to hospitals for inpatient hospital services to Medicaid patients, each eligible hospital, excluding free-standing psychiatric hospitals, shall receive inpatient hospital access payments each fiscal year. Inpatient hospital access payments shall include the following:

(1) An inpatient access payment to hospitals determined on a quarterly basis by the Alabama Medicaid Agency that complies with paragraph (3) below. Aggregate hospital access payments for each category of hospitals will be the amount calculated in paragraph (k)(7) for state owned or operated hospitals and the amount calculated in paragraph (l)(10) for non state government owned and operated hospitals and private hospitals. Annual amount to be paid for each State Fiscal Year will be made as indicated in paragraph (3) on page 6H.
(2) These additional inpatient hospital access payments shall be made on a quarterly basis.
(3) The inpatient hospital access payments shall not exceed the annual applicable hospital inpatient upper payment limit Gap for each category of hospitals submitted to CMS.

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(n) For the period October 1, 2019, through September 30, 2020, 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 $275 per Medicaid inpatient day paid based on the Medicaid days per the cost report ending during the State Fiscal Year 2018.

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IV. PROVIDERS WHICH SERVE A DISPROPORTIONATE NUMBER OF LOW INCOME PATIENTS

Certain payment adjustment shall be provided for hospitals which are determined to be adversely affected because they serve a disproportionate number of low income patients.

(a) In order to be eligible for this payment adjustment, a hospital shall meet the following criteria:

(1) The hospital's Medicaid inpatient utilization rate exceeds one standard deviation above the mean Medicaid inpatient utilization rate of all in-state hospital providers participating in the Alabama Medicaid Program; or

(2) The hospital's low-income inpatient utilization rate exceeds 25 percent; or

(3) Be an acute care teaching hospital operated by a university of the State of Alabama; or

Effective Date: 10/01/94

(4) Be an acute care publicly owned hospital; or

Effective Date: 10/01/95

(5) Be an acute care hospital that is a member of a prepaid health plan; or

Effective Date: 01/01/95

(6) Acute care hospitals in a county, with a population greater than 200,000 (according to the latest U. S. census), without a publicly owned hospital, whose Medicaid utilization exceeds the state wide Medicaid utilization average; or

(7) Acute care hospitals in a county, with a population not less than 75,000 and not greater than 100,000 (according to the latest U. S. census), without a publicly owned hospital, whose Medicaid utilization exceeds one-half of the state wide Medicaid utilization average; and

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(8) Effective for services rendered on or after July 1, 1988, the hospital must have at least two (2) obstetricians with staff privileges at the hospital who have agreed to provide non-emergency obstetric services to individuals entitled to such services under the Alabama Medicaid Program. (In the case of a hospital located in an area designated by Medicaid as rural, the term "obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures.) Hospitals that did not offer routine obstetrical services to the general public as of December 21, 1987, or whose inpatients are predominantly individuals under 18 years of age are exempt from this requirement. Should a hospital begin offering non-emergency OB services on or after December 21, 1987, the requirement to have two obstetricians applies; and

Effective Date: 10/01/94

(9) Have a Medicaid inpatient utilization rate of not less than one percent.

Effective Date: 10/01/93

(b) If the applicable criteria in (a) above are met, then the payment adjustment shall be determined as follows:

(1) A factor of one quarter of one percent for every percentage point the hospital's Medicaid inpatient utilization rate exceeds one standard deviation above the mean Medicaid inpatient utilization rate (with a minimum of one quarter of one percent), or for every percentage point the hospital's Low-Income Utilization Rate exceeds twenty-five percent shall be computed.

(2) The applicable factor from (b)(1) above shall be applied to the hospital's allowable calculated per diem rate (excluding any education cost flow-through). The hospital shall be reimbursed its factored per diem rate plus any applicable education cost flow-through.

(3) In the instance of a hospital meeting two or more of the applicable criteria contained within section (a), two or more factored per diems shall be calculated, using the
Medicaid Inpatient Utilization factor and the Low-Income Utilization factor as in (b)(1) above. The hospital shall be reimbursed at the lower of the two factored per diems plus any applicable education cost flow-through.

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Disproportionate share payments to any public hospital shall not exceed uncompensated cost of care as defined in OBRA 93.

(c) As an alternative payment method, based upon availability of funds to be appropriated, hospitals that meet the applicable criteria in Section IV(a) above and which do not have their disproportionate share payment included in a capitation payment rate shall be compensated as follows:

(1) Disproportionate share hospitals shall be grouped into eight groups as follows:
Group 1: Acute care hospitals whose inpatients are predominantly under 18 years of age.
Group 2: Acute care publicly owned hospitals.
Group 3: Acute care hospitals located in a rural area and acute care hospitals licensed for one-hundred (100) beds or less and located in a metropolitan statistical area (MSA).

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Group 4: Psychiatric hospitals owned and operated by the State of Alabama.
Group 5: Psychiatric hospitals, other than those owned and operated by the State of Alabama, which provide services to individuals under 21 years of age.

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Group 6: Acute care hospitals in a county, with a population greater than 200,000 (according to the latest U. S. census), without a publicly owned hospital, whose Medicaid utilization exceeds the statewide Medicaid utilization average.
Group 7: Acute care hospitals in a county, with a population not less than 75,000 and not greater than 100,000 (according to the latest U.S. census), without a publicly owned hospital, whose Medicaid utilization exceeds one-half of the state wide Medicaid utilization average.

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Group 8: Hospitals which are members of a prepaid health plan.

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(2) Annually, the Alabama Medicaid Agency shall determine a sum of funds to be appropriated to each group of hospitals, in lieu of the payment methodology contained in Section IV(b). Disproportionate share payments to any public hospital shall not exceed uncompensated cost of care as defined in OBRA 93. Subject to this limitation, calculation of the payments shall be as follows:

(A) Group 1

$$\frac{\text{Uncompensated Cost}}{\text{Total Uncompensated Cost for Hospitals in Group One}} \times \text{Appropriated Funds} = \text{Disproportionate Share Payment}$$

(B) Group 2

$$\frac{\text{Uncompensated Cost}}{\text{Total Uncompensated Cost for Hospitals in Group Two}} \times \text{Appropriated Funds} = \text{Disproportionate Share Payment}$$

(C) Group 3

$$\frac{\text{Medicaid Inpatient Days}}{\text{Total Medicaid Inpatient Days for Hospitals in Group Three}} \times \text{Appropriated Funds} = \text{Disproportionate Share Payment}$$

(D) Group 4

$$\frac{\text{Medicaid Inpatient Days}}{\text{Total Medicaid Inpatient Days for Hospitals in Group Four}} \times \text{Appropriated Funds} = \text{Disproportionate Share Payment}$$

(E) Group 5

$$\frac{\text{Medicaid Inpatient Days}}{\text{Total Medicaid Inpatient Days for Hospitals in Group Five}} \times \text{Appropriated Funds} = \text{Disproportionate Share Payment}$$

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(F) Group 6

$$\frac{\text{Hospital}}{\text{Total hospitals in Group Six}} \times \text{Appropriated Funds} = \text{Disproportionate Share Payment}$$

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(G)	Group 7 Hospital Total hospitals in Group Seven	X	Appropriated Funds	=Disproportionate Share Payment
(H)	Group 8 Uncompensated care Total Uncompensated care in Group Eight	X	Appropriated Funds	=Disproportionate Share Payment

Note: Aggregate appropriated funds will not exceed the disproportionate share hospital payments limits in 42 CFR §447.296 through §447.299.

If a hospital meets the criteria in IV(a) and does not fall into one of the payment groupings in IV(c), they would be paid using section IV(b).

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(3) In the event funds are not available to be appropriated for distribution under this methodology, these hospitals shall be reimbursed in accordance with the methodology contained in Section IV (b).

(d) The payment shall be an amount that is reasonable related to costs, volume, or proportion of services provided to patients eligible for medical assistance under the State Plan and to low income patients.

(e) Alabama shall pay these hospitals at least the minimum payment adjustment as specified in Section IV(b) of the State Plan and no more than that determined to be available in IV(c)(2) of this section.

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Effective Date: 10/01/18

(f) For the period from October 1, 2018, to September 30, 2019, 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 up to each hospital's allowable uncompensated care cost under the hospital specific DSH limit in Section 1923(g) of the Social Security Act as outlined in Exhibit C. State owned institutions for mental disease shall receive no more than the IMD allotment.

(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 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, using their available cost in relation to total private cost. 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.

(6) An initial disproportionate share hospital payment to each hospital shall be made during the first month of the state fiscal year. Additional disproportionate share hospital payments may be made during the fiscal year based on analysis of payments during the fiscal year and changes in Federal allocations. Payments to privately owned and operated hospitals will be made as indicated in paragraph (5) on page 8D.

(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.

Beginning with the audit of the Medicaid State Plan Rate Year ended September 30, 2011, the definition of individuals who have no health insurance (or other source of third party coverage) will be based on the definition published in the December 3, 2014, Federal Register, with an effective date of December 31, 2014.

The Medicaid Agency will recoup funds from any 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) The amount of the DSH payment made to the hospital will be recouped by the Alabama Medicaid Agency to the extent necessary to reduce the DSH payment to an allowable amount.

(b) Amounts recouped from privately owned and operated hospitals with payments in excess of the audited hospital specific DSH limits, will be placed into a redistribution pool. Redistribution will be made to remaining privately owned and operated hospitals that do not exceed their hospital specific DSH limit. The allocation will be made based on these remaining hospitals available uncompensated care. No privately owned and operated hospital shall exceed its hospital specific DSH limit after redistribution. If any private DSH payments cannot be redistributed within this ownership group, the remaining DSH payments after redistribution to privately owned and operated hospitals will be placed in the redistribution pool described in paragraph (7)(c) on page 8E for qualifying non-state government and state owned disproportionate share hospitals. If any privately owned and operated DSH payments remain after being placed in the redistribution pool described in paragraph (7)(c) on page 8E, the Federal Share of the DSH payments that remain will be returned to the Federal Government.

(c) Amounts recouped from qualifying non-state government and state owned disproportionate share hospitals with payments in excess of the audited hospital specific DSH limits, along with any remaining DSH payments from paragraph (7)(b) on page 8E will be placed into a redistribution pool. Redistribution will be made to remaining qualifying non-state government and state owned disproportionate share hospitals that do not exceed their hospital specific DSH limit. The allocation will be made based on these remaining hospitals available uncompensated care. No qualifying non-state government and state owned disproportionate share hospital shall exceed its hospital specific DSH limit after redistribution. If any qualifying non-state government and state owned DSH payments cannot be redistributed within this ownership group, the remaining DSH payments after redistribution to qualifying non-state government and state owned hospitals will be placed in the redistribution pool described in paragraph (7)(b) on page 8E. If any qualifying non-state government and state owned DSH payments remain after being placed in the redistribution pool described in paragraph (7)(b) on page 8E, the Federal Share of the DSH payments that remain will be returned to the Federal Government.

For Medicaid State Plan Rate Years Ended September 30, 2011 through September 30, 2013:

(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.

For Medicaid State Plan Rate Years ending September 30, 2014 through September 30, 2016:

(a) The amount of the DSH payment made to the hospital will be recouped by the Alabama Medicaid Agency to the extent necessary to reduce the DSH payment to an allowable amount.

(b) Amounts recouped from privately owned and operated hospitals with payments in excess of the audited hospital specific DSH limit will be placed into a redistribution pool. Redistribution will be made to remaining privately owned and operated hospitals that do not exceed their hospital specific DSH limit. The allocation will be made based on these remaining hospitals available uncompensated care. No hospital shall exceed its hospital specific DSH limit after redistribution.

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V. RATE OF RETURN ON EQUITY CAPITAL

The rate of return on average equity capital is a percentage equal to the average of the rates of interest on special issues of public debt obligations issued to the Federal Hospital Insurance Trust Fund for each of the months during the provider's reporting period or portion thereof covered under the program. The rate of return varies as the interest rates on such issues of public debt obligations vary.

VI. APPROVED CAPITAL EXPENDITURE PROJECTS

(a) Regardless of any other provision in this state plan, the Alabama Medicaid Agency will not recognize any capital project construction costs arising from bed additions, renovation, or any other construction resulting from a Certificate of Need (CON) dated on or after October 1, 1983. (Replacement of equipment is not affected by this limitation.)

(b) For those hospitals with approved capital expenditure projects resulting from a CON dated prior to October 1, 1983, the following procedures and/or any other procedures deemed necessary by the Agency will be performed to reimburse the approved CON projects of those hospitals which qualify under the above listed circumstances:

(1) The hospital will submit a budgeted cost report containing estimated total Medicaid cost.

(2) The Agency will compute a budgeted per diem rate subject to the current ceiling. This rate must exceed the hospital's current rate by 10% (if the current rate is not

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limited by the overall ceiling) in order to be considered for a rate, increase.

(3) The total budgeted rate is subject to retroactive adjustment after comparison to the rate calculated from the applicable cost report containing actual allowable costs.

VII. RECORDS

(a) All hospitals must keep financial and statistical records which document and justify costs. Only those costs which can be fully and properly substantiated will be allowed by Medicaid. All records must be available upon request to representatives, employees, or contractors of the Alabama Medicaid Agency, Alabama Department of Examiners of Public Accounts, General Accounting Office (GAO), or the United States Department of Health and Human Services (HHS).

(b) The records of related organizations must be available upon demand to those individuals or organizations as listed in Section VII.(a) of this plan.

Effective Date: 07/01/88

(c) The Alabama Medicaid Agency shall retain all uniform cost reports submitted for a period of at least three (3) years following the date of submission of such reports and will maintain those reports pursuant to the record keeping requirements of 42 CFR 447.203(a) and 42 CFR 433.32. If an audit by or on behalf of the state or federal government has begun, but is not completed at the end of the three year period, or if audit findings have not been resolved at the end of the three year period, the reports shall be retained until resolution of the audit findings.

Effective Date: 06/01/90

VIII. **COST REPORT PENALTIES**

(a) Failure to File a Cost Report

1. Each Alabama hospital participating in the Alabama Medicaid program shall submit a cost report in the manner prescribed by the Alabama Medicaid Agency. If a complete uniform cost report is not filed by the due date (90 days after the Medicaid elected FYE), the hospital shall be charged a penalty of one hundred dollars ($100.00) per day for each calendar day after the due date. This penalty will not be a reimbursable Medicaid cost. The Commissioner of Medicaid may waive such penalty for good cause shown. Such showing must be made in writing to the Commissioner with supporting

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documentation. A cost report that is over ninety (90) days late may result in termination of the hospital from the Medicaid program.

2. Further, the entire amount paid to the hospital during the fiscal period with respect to which the report has not been filed will be deemed an overpayment. The hospital will have thirty (30) days to refund the overpayments or submit the cost report after which Medicaid may institute a suit or other action to collect this overpayment amount. No further payment will be made to the hospital until the cost report has been received by Medicaid.

(b) Reporting Negligence

1. Whenever a provider includes a previously disallowed cost on a subsequent years' cost report, if the cost included is attributable to the same type good or service under substantially the same circumstances as resulted in the previous disallowance, a negligence penalty of up to $10,000 may be assessed at the discretion of the Alabama Medicaid Agency.

2. The penalty imposed under item (b)(1) above shall be in addition, and shall in no way affect Medicaid's right to also recover the entire amount of any overpayment caused by the provider's, or its representative's negligence.

3. A previously disallowed cost, for the purposes of a negligence penalty assessment, is a cost previously disallowed as the result of a desk review or a field audit of the provider's cost report by Medicaid and such cost has not been reinstated by a voluntary action of Medicaid. The inclusion of such cost on a subsequent cost report by the provider, or its representative, unless the provider is pursuing an administrative or judicial review of such disallowance, will be considered as negligent and subject to the penalty imposed by this rule.

IX. AUDIT

To insure that payment of inpatient hospital costs is being made on a reasonable basis, comprehensive hospital desk review and audit programs have been developed (42 CFR 447.202). Using these programs, Medicaid shall perform the following:

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(a) Desk review the cost reports as filed and include only the appropriately determined allowable cost in the prospective per diem rate calculations.

(b) Determine the necessity, scope, and format for on-site audits.

(c) Perform on-site audits when indicated in accordance with Title XIX Principles of Reimbursement.

(d) Recalculate, when appropriate, the prospectively determined per diem rate giving effect to audit adjustments.

X. PAYMENT ASSURANCE

The Medicaid Agency will pay each hospital which furnishes allowable services, in accordance with the requirements of the State Plan, the amount determined for services furnished by the hospital according to the standards and methods set forth in the Alabama Title XIX Inpatient Hospital Reimbursement Plan.

XI. PROVIDER PARTICIPATION

Payments made in accordance with the standards and methods described in this attachment are designed to enlist participation of a sufficient number of hospitals in the program so that eligible persons can receive the medical care and services included in the State Plan at least to the extent available to the general public.

XII. PAYMENT IN FULL

Participation in the program shall be limited to hospitals who accept, as payment in full, the amount paid in accordance with the State Plan.

XIII. UPPER LIMITS

In no instance will the Medicaid per diem rate exceed, in the aggregate, the amount which would be paid by Medicare for comparable inpatient services.

XIV. APPEALS

(1) Except as herein prohibited, any provider of hospital services under the Medicaid program may appeal any action resulting from the provisions of the State Plan in accordance with the

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normal appeals procedures of the Alabama Medicaid Program. The following items will not be subject to appeals under these procedures:

(a) The use of Medicaid standards and principles of reimbursement.

(b) The method of determining the trend factor.

(c) The use of all-inclusive prospective reimbursement rates.

(d) The use of hospital group ceilings.

(2) A hospital may, on the basis of appeal, be granted an exception for one rate period only. Any further exceptions must be appealed individually. As a condition of appeal, the Alabama Medicaid Agency may require the hospital to submit to a comprehensive operational review. Such review will be made at the discretion of the Alabama Medicaid Agency and may be performed by it or its designee. The findings from any such review may be used to recalculate allowable costs for the hospital.

XV. CO-PAY

Effective Date: 09/01/86

Per diem payments are subject to co-pay; the amount of co-pay per admission is listed in Section 4.18-A of the State Plan.

XVI. PAYMENT FOR SERVICES RENDERED AT AN INAPPROPRIATE LEVEL OF CARE

Effective Date: 08/01/94

(1) Reimbursement will be made for medically necessary services rendered at an inappropriate level of care (lower than acute). Medical necessity will be determined for eligible individuals by applying the following:

(a) Medical need criteria for services routinely provided by a nursing facility;

(b) Verification of no less than a three-day stay (consecutive) for acute care services; and

(c) Verification of the non-availability of a nursing facility bed.

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(2) Reimbursement will be made on a per diem basis at the statewide nursing facility average rate per paid day for routine services furnished during the previous calendar year.

(3) Initial certification will not exceed thirty (30) days. If the patient is not placed in a nursing facility at the end of the initial thirty (30) day period, recertification may be made every additional thirty (30) days based on prior authorization by Medicaid.

XVII. THIRD PARTY PAYMENTS

In the event a Medicaid patient has insurance coverage for inpatient services provided by a hospital, the hospital is required to file for the patient's insurance before a claim for Medicaid payment may be filed. The Medicaid claim must indicate the amount of third party payment received or attach a copy of a rejection notice. Reimbursement to a hospital for inpatient services to eligible Medicaid patients will be made only after such reimbursement has been reduced by all third party payments.

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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.

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A hospital having a claim which meets the criteria for a cost outlier must present the claim(s) documentation to the Alabama Medicaid Agency for review after the claim(s) have been adjudicated. Subsequent to review and approval, payment shall be made as a lump sum.

XX. MISCELLANEOUS

(a) The Alabama Medicaid Agency will utilize appropriate methods of notifying the public concerning proposed substantial changes in methods and/or standards, and prior to the implementation of any substantial change in methods and/or standards, the public will have an opportunity to review and comment on the proposed changes.

(b) Detailed information regarding the reimbursement methodology and related matters appears in Chapter 23 of the Alabama Medicaid Agency Administrative Code.

EXHIBIT A

LOW OCCUPANCY ADJUSTMENT FOR URBAN HOSPITALS

$$LOA \quad \left(1 - \frac{TBD}{YABD} \right) \quad ACC$$

TBD = Total Bed Days Actually Used During the Cost Report Period Exclusive of Nursery Bassinets and/or Separately Certified non-Covered Units (i.e. Psych.).

ABD = Available Bed Days Which is Determined by Multiplying the Total Licensed Beds Times the Number of Days in the Cost Report Period Exclusive of Nursery Bassinets and/or Separately Certified non covered Units (i.e. psych.)

ACC = Allowable Capital Costs

Y = Occupancy Factor

(Y = 70% 100 beds or less)
(Y = 80% 101 beds or less)

EXHIBIT B
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NATIONAL MARKET BASKET PRICE PROXIES
HOSPITAL INPATIENT OPERATING COSTS

EXPENSE CATEGORY	RELATIVE WEIGHT*	HCFA-DESIGNATED PRICE VARIABLE
Wages & Salaries	57.24	Average Hourly Earnings, Hospital Workers (SIC 806)
Employee Benefits	8.22	Supplements to Wages and Salaries per Employee in Nonagricultural Establishments
Professional Fees, Medical	--	Consumer Price Index, All Urban Physicians' Services
Professional Fees, Other	0.59	Index of Hourly Earnings of Production Workers, Private Nonfarm
Malpractice Insurance Premiums	1.96	Hospital Malpractice Insurance Premiums
Food	3.56	a. Consumer Price Index, All Urban, Food and Beverages b. Producer Price Index, Processed Food and Feeds
Fuel & Other Utilities	2.76	a. Implicit Price Deflator, Consumption of Fuel Oil and Coal b. Implicit Price Deflator Consumption of Electricity c. Implicit Price Deflator Consumption of Natural Gas d. Consumer Price Index, All Urban, Water and Sewerage Maintenance
Drugs	2.82	Producer Price Index, Preparations, Ethical (Prescription)

EXHIBIT B
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Chemicals and Cleaning Products	2.15	Producer Price Index, Chemicals and Allied Products
Surgical and Medical Instruments and Supplies	2.03	Producer Price Index, Special Industry Machinery and Equipment
Rubber and Miscellaneous Plastics	1.84	Producer Price Index, Rubber and Plastic Products
Business Travel & Motor Freight	1.72	Producer Price Index, Textile Products and Apparel
Apparel and Textiles	1.65	Consumer Price Index, Textile Products and Apparel
Business Services	4.70	Consumer Price Index, All Urban, Services
All Other Miscellaneous	8.76	Consumer Price Index, All Urban, All Items
	100.0	

*HCFA input price index excludes capital, medical education, and medical professional fees. Weights are based on HCFA special studies.

The above relative weights are per Data Resources, Inc. (Health Care Costs) Volume V, Number 7, 3rd Quarter 1985 Series.

The National Hospital Input Price Index methodology will be utilized to isolate the effects of prices of goods and services for Alabama hospitals. Such an index will measure the average percent change in prices for a fixed "market basket" of hospital categories of expenses as forecasted by Data Resources, Inc. (Data Resources, Inc., Cost Forecasting Service, Regional Forecasting Models for Selected Components of the Hospital and Nursing Home Cost Index, 1750 K Street, Washington, DC 20006). Such a forecast combined with the historical period data, will provide a price index for hospital inpatient reimbursement in the state.

The National Hospital Input Price Index was developed utilizing a fixed set of weights for each of seven (7) categories of expenses. The article by Freeland, et al., in the HCFA Review (Summer 1979) discussed the various "market basket" comparisons, input-output data, and other survey designs which were utilized in the establishment of the Price Index. These were further refined by Data Resources, Inc., to provide a total of fourteen (14) basic Expense Categories. Relative cost weights were established from 1977 data to establish the final National Market Basket Price Proxies published in Health Care Costs (Data Resources, Inc., Vol. 1, No. 1, May 1981). This publication will provide market basket forecasts for a total of sixteen (16) quarters in order to permit a detailed analysis of the basic input categories of goods and services purchased by a hospital or provided to employees through wages and benefits.

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

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 the uninsured

1. Calculation of Interim Disproportionate Share Hospital (DSH) Limit: A base year will be used to calculate the cost of the uninsured and Medicaid eligible beneficiaries. The base year will be the State fiscal year with the most recent DSH audit being completed. 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.

   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 hospital covered charges will be multiplied by the CCR to determine Medicaid cost. All payments made related to these Medicaid hospital covered charges would be used to offset the Medicaid cost to determine uncompensated Medicaid hospital cost.

c. The inpatient and outpatient hospital 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 hospital services for individuals with no source of third party insurance will be combined with the uncompensated Medicaid hospital cost to determine the uncompensated care cost. Any Medicaid hospital payments in excess of Medicaid hospital 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 by applying the Global Insight Health-Care Cost Review from the mid-point of the cost reporting fiscal year to the mid-point of the next State Fiscal Year and then from mid-point of the State fiscal year to the mid-point of the current State Fiscal Year.

2. 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 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.

Each hospital will supply the State with covered detailed days and covered charges information for services provided to Medicaid eligible individuals paid through the Alabama Medicaid Management Information System 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 hospital cost of services for inpatient routine care services, inpatient ancillary services, and outpatient ancillary services will be determined in accordance with the DSH final rule published on December 19, 2008 and the CMS General DSH Audit Reporting Protocol 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.
Medicaid FFS Medicaid Eligible Outpatient Ancillary Cost for Acute and Sub-Provider Services	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. For each organ type, Total Organ Acquisition cost per Worksheet D-4 Part III Line 60 Column 1 will be divided by Total Usable Organs per Worksheet D-4 Part III Line 61 Column 1 to determine the cost per organ for each organ type. The cost per organ for each organ type will be multiplied by the number of organs transplanted obtained from the State's MMIS system for Alabama Fee for Service and from the hospital's internal records for Medicaid Managed Care and Medicaid Out Of State services. Medicare/Medicaid Dual Eligibles individuals will not be included as the amount for Medicaid Services would be offset by the amount reimbursed by Medicare Services.

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 less the payments received for CRNA 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 hospital services provided to individuals with no source of third party insurance shall be calculated as follows:

a. The cost of hospital services for inpatient routine care services, inpatient ancillary services, outpatient ancillary services, and transplant services will be determined in accordance with the DSH final rule published on December 19, 2008 and the CMS General DSHA Audit Reporting Protocol 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 23 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.

b. For each organ type, Total Organ Acquisition cost per Worksheet D-4 Part III Line 60 Column 1 will be divided by Total Usable Organs per Worksheet D-4 Part III Line 61 Column 1 to determine the cost per organ for each organ type. The cost per organ for each organ type will be multiplied by the number of organs transplanted obtained from the hospital's internal records for individuals with no source of third party insurance.

c. Combining the cost of uninsured routine services, cost of uninsured inpatient ancillary services, cost of uninsured outpatient ancillary services, the cost of uninsured organ acquisition costs plus the Medicaid portion of CRNA expense removed on Worksheet A-8 based on the uninsured utilization of uninsured charges divided by total charges 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 hospital services for individuals with no source of third party insurance will be combined with the uncompensated cost of care for hospital 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 hospital 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.

e. 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.

If necessary, each hospital will supply the State with updated covered detailed days and covered charges information for services provided to Medicaid eligible individuals paid through the Alabama Medicaid Management Information System 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 in accordance with the DSH final rule published on December 19, 2008 and the CMS General DSH Audit Reporting Protocol 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 23 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.
Medicaid FFS Medicaid Eligible Routine Service Cost For Sub-Provider Services	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.
Medicaid FFS Medicaid Eligible Routine Service Cost For Sub-Provider Services	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.
Medicaid FFS Medicaid Eligible Inpatient Ancillary Cost for Acute and Sub-Provider Services	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.
Medicaid FFS Medicaid Eligible Outpatient Ancillary Cost for Acute and Sub-Provider Services	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. For each organ type, Total Organ Acquisition cost per Worksheet D-4 Part III Line 60 Column 1 will be divided by Total Usable Organs per Worksheet D-4 Part III Line 61 Column 1 to determine the cost per organ for each organ type. The cost per organ for each organ type will be multiplied by the number of organs transplanted obtained from the State's MMIS system for Alabama Fee for Service and from the hospital's internal records for Medicaid Managed Care and Medicaid Out Of State services. Medicare/Medicaid Dual Eligibles individuals will not be included as the amount for Medicaid Services would be offset by the amount reimbursed by Medicare Services.

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 less the payments received for CRNA services will represent the cost of Medicaid eligible hospital services.

d. The payments received related to Medicaid hospital 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 hospital services provided to individuals with no source of third party insurance shall be calculated as follows:

a. The cost of hospital services for inpatient routine care services, inpatient ancillary services, outpatient ancillary services, and transplant services will be determined in accordance with the DSH final rule published on December 19, 2008 and the CMS General DSH Audit Reporting Protocol 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 23 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. For each organ type, Total Organ Acquisition cost per Worksheet D-4 Part III Line 60 Column 1 will be divided by Total Usable Organs per Worksheet D-4 Part III Line 61 Column 1 to determine the cost per organ for each organ type. The cost per organ for each organ type will be multiplied by the number of organs transplanted obtained from the hospital's internal records for individuals with no source of third party insurance.

c. Combining the cost of uninsured routine services, cost of uninsured inpatient ancillary services, cost of uninsured outpatient ancillary services, the cost of uninsured organ acquisition 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 to determine the total cost of hospital 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 hospital 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 of hospital services. Any Medicaid payments in excess of Medicaid cost will be used to offset uncompensated care of hospital 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.

Listing of Inpatient Access Payments and Disproportionate Share Hospital Payments

Inpatient access payments and DSH payments distributed to individual hospitals include consideration of the following factors; Hospital Cost, OBRA limits, hospital charges, overall UPL GAP by hospital category, and other special circumstances. The payments for each hospital are noted below for rate year 2014.

Inpatient Access Payments for the State Fiscal Year Ended September 30, 2014

State Owned and Operated Hospitals

Facility	Inpatient Access Payments
UNIVERSITY OF ALABAMA	59,707,266
USA CHILDRENS & WOMENS HOSPITAL	8,932,741
USA MEDICAL CTR HOSP	24,344,371
Total State Owned and Operated Hospitals	92,984,378

Non-State Government Owned and Operated Hospitals

Facility	Inpatient Access Payments
ATHENS LIMESTONE HOSP	2,790,129
GULF HEALTH HOSPITALS DBA THOMAS HOSPITAL	322,014
BAPTIST MEDICAL CENTER EAST	9,176,040
BAPTIST MEDICAL CTR SOUTH	24,437,969
BIBB MEDICAL CENTER HOSPITAL	1,217,948
BRYAN W WHITFIELD MEMORIAL H	1,946,778
CALLAHAN EYE FOUNDATION HOSPITAL	4,402
COOSA VALLEY MEDICAL CENTER	1,810,995
CULLMAN REG MEDICAL CENTER	2,401,431
D.W. MCMILLAN MEMORIAL HOSPITAL	69,431
DALE MEDICAL CENTER	341,132
DCH REGIONAL MEDICAL CENTER	8,382,898
DECATUR GENERAL HOSPITAL	2,490,010
EAST AL MEDICAL CENTER	4,469,272

Facility	Inpatient Access Payments
ECACH INC/ATMORE COMMUNITY H	219,480
GREENE COUNTY HOSPITAL	1,145,673
GROVE HILL MEMORIAL HOSPITAL	915,665
HALE COUNTY HOSPITAL	105,630
HELEN KELLER HOSPITAL	1,905,966
HIGHLANDS MEDICAL CENTER	694,160
HILL HOSPITAL OF SUMTER COUN	654,699
HUNTSVILLE HOSPITAL	9,964,993
JPAUL JONES HOSPITAL	1,379,061
LAWRENCE MEDICAL CENTER	251,433
MARSHALL MEDICAL CENTER SOUT	2,640,614
MEDICAL CENTER BARBOUR	1,830,240
MEDICAL WEST	4,016,017
MONROE COUTNY HOSPITAL	936,472
NORTH BALDWIN INFIRMARY	601,205
NORTHEAST AL REGIONAL MED CT	4,378,541
PARKWAY MEDICAL CENTER	2,416,292
PICKENS COUNTY MEDICAL CTR	711,832
PRATTVILLE BAPTIST HOSPITAL	539,682
RED BAY HOSPITAL	77,885
SOUTHEAST ALABMAM MED CTR	4,661,216
TROY REGIONAL MEDICAL CENTER	1,626,880
WASHINGTON COUTNY HOSPITAL	2,490
WEDOWEE HOSPITAL	183,136
WIREGRASS MEDICAL CENTER	547,613
Total Non-State Government Owned and Operated Hospitals	102,267,324

Privately Owned and Operated Hospitals

Facility	Inpatient Access Payments
ANDALUSIA REGIONAL HOSPITAL	3,990,633
BULLOCK COUTNY HOSPITAL	1,689,107
CHOCTAW COMMUNITY HOSPITAL	394,702
CITIZENS BAPTIST MEDICAL CTR	7,913,736
COMMUNITY HOSPITAL	2,391,836
EVERGREEN MEDICAL CENTER	1,436,994
FLORALA MEMORIAL HOSPITAL	86,576
FLOWERS HOSPITAL	11,643,691
GEORGIANA HOSPTIAL	725,321
HEALTHSOUTHLAKESHORE HOSPITAL	76,319
JACK HUGHSTON MEMORIAL HOSPITAL	1,036,368
JACKSON HOSPITAL & CLINIC	13,106,429
LAKE MARTIN COMMUNITY HOSPITAL	766,445
LV STABLER MEMORIAL HOSPITAL	1,153,425
MOBILE INFIRMARY	26,587,178
NORTHWEST MEDICAL CENTER	2,655,614
RIVERVIEW REGIONAL MED CTR	9,481,887
RUSSELL HOSPITAL	5,580,241
SHOALS HOSPITAL	2,484,355
SPRINGHILL MEM HOSP	4,327,767
ST VINCENTS EAST	11,614,723
THE CHILDRENS HOSPITAL OF ALABAMA	84,970,068
TRINITY MEDICAL CENTER	12,015,100
WALKER BAPTIST MEDICAL CENTE	11,766,024
PROFESSIONAL RESOURCES MANAGEMENT PSYCHIATRIC SERV **X**	1,265,690
LAUREL OAKS BEHAVIORAL HEALTH CEN **X**	1,404,023
MOUNTAIN VIEW HOSPITAL **X**	1,080,702
HILL CREST BEHAVIORAL HLTH S **X**	1,924,132
BAYPOINTE BEHAVIORAL HEALTH **X**	975,772
Total Privately Owned and Operated Hospitals	224,544,858

X - Privately owned and operated psychiatric hospitals

Privately Owned or Operated Disproportionate Share Hospitals

Facility	DSH Payments
BAPTIST MED CENTER – PRINCET	17,584,820
BROOKWOOD MEDICAL CENTER	9,638,674
CHEROKEE MEDICAL CENTER	1,781,512
CRENSHAW COMMUNITY HOSPITAL	1,678,193
CRESTWOOD MEDICAL CENTER	6,955,069
DEKALB REGIONAL MEDICAL CENTER	5,122,720
ELIZA COFFEE MEMORIAL HOSPIT	13,554,240
ELMORE COMMUNITY HOSPITAL	815,865
FLORALA MEMORIAL HOSPITAL	220,398
GADSDEN REGIONAL MEDICAL CTR	13,738,710
GEORGE H LANIER MEMORIAL HOS	3,050,666
JACKSON MEDICAL CENTER	1,626,969
LAKELAND COMMUNITY HOSPITAL	2,250,346
MARION REGIONALMEDICAL CENTE	1,434,038
MIZELL MEMORIAL HOSPITAL	1,611,782
PROVIDENCE HOSPITAL	13,405,106
QHG OF ENTERPRISE INC	4,862,051
RUSSELLVILLE HOSPITAL	6,424,464
SHELBY BAPTIST MEDICAL CENTE	14,810,456
SOUTH BALDWIN REGIONAL MED C	5,761,895
SPRINGHILL MEM HOSP	1,717,510
ST VINCENTS BLOUNT	2,581,742
ST VINCENTS EAST	739,894
ST VINCENTS HOSPITAL	9,216,258
ST VINCENTS ST CLAIR	2,121,849
STRINGFELLOW MEM HOSP	4,811,552
TRINITY MEDICAL CENTER	785,561
VAUGHAN REG MED CTR PARKWAY CAMPU	9,461,712

NOTE: State owned and operated hospitals and non-State government owned and operated hospitals initial DSH payments will be determined with the CPE estimate in Exhibit C of this attachment and final payments will be determined through the DSH audit process and the CPE reconciliations in Exhibit C of this attachment.

EXHIBIT A

LOW OCCUPANCY ADJUSTMENT FOR URBAN HOSPITALS

$$LOA \quad \left(1 - \frac{TBD}{YABD} \right) \quad ACC$$

TBD = Total Bed Days Actually Used During the Cost Report Period Exclusive of Nursery Bassinets and/or Separately Certified non-Covered Units (i.e. Psych.).

ABD = Available Bed Days Which is Determined by Multiplying the Total Licensed Beds Times the Number of Days in the Cost Report Period Exclusive of Nursery Bassinets and/or Separately Certified non covered Units (i.e. psych.)

ACC = Allowable Capital Costs

Y = Occupancy Factor

(Y = 70% 100 beds or less)
(Y = 80% 101 beds or less)

EXHIBIT B
Page 1

NATIONAL MARKET BASKET PRICE PROXIES
HOSPITAL INPATIENT OPERATING COSTS

EXPENSE CATEGORY	RELATIVE WEIGHT*	HCFA-DESIGNATED PRICE VARIABLE
Wages & Salaries	57.24	Average Hourly Earnings, Hospital Workers (SIC 806)
Employee Benefits	8.22	Supplements to Wages and Salaries per Employee in Nonagricultural Establishments
Professional Fees, Medical	--	Consumer Price Index, All Urban Physicians' Services
Professional Fees, Other	0.59	Index of Hourly Earnings of Production Workers, Private Nonfarm
Malpractice Insurance Premiums	1.96	Hospital Malpractice Insurance Premiums
Food	3.56	a. Consumer Price Index, All Urban, Food and Beverages b. Producer Price Index, Processed Food and Feeds
Fuel & Other Utilities	2.76	a. Implicit Price Deflator, Consumption of Fuel Oil and Coal b. Implicit Price Deflator Consumption of Electricity c. Implicit Price Deflator Consumption of Natural Gas d. Consumer Price Index, All Urban, Water and Sewerage Maintenance
Drugs	2.82	Producer Price Index, Preparations, Ethical (Prescription)

EXHIBIT B
Page 2

Chemicals and Cleaning Products	2.15	Producer Price Index, Chemicals and Allied Products
Surgical and Medical Instruments and Supplies	2.03	Producer Price Index, Special Industry Machinery and Equipment
Rubber and Miscellaneous Plastics	1.84	Producer Price Index, Rubber and Plastic Products
Business Travel & Motor Freight	1.72	Producer Price Index, Textile Products and Apparel
Apparel and Textiles	1.65	Consumer Price Index, Textile Products and Apparel
Business Services	4.70	Consumer Price Index, All Urban, Services
All Other Miscellaneous	8.76	Consumer Price Index, All Urban, All Items
	100.0	

*HCFA input price index excludes capital, medical education, and medical professional fees. Weights are based on HCFA special studies.

The above relative weights are per Data Resources, Inc. (Health Care Costs) Volume V, Number 7, 3rd Quarter 1985 Series.

The National Hospital Input Price Index methodology will be utilized to isolate the effects of prices of goods and services for Alabama hospitals. Such an index will measure the average percent change in prices for a fixed "market basket" of hospital categories of expenses as forecasted by Data Resources, Inc. (Data Resources, Inc., Cost Forecasting Service, Regional Forecasting Models for Selected Components of the Hospital and Nursing Home Cost Index, 1750 K Street, Washington, DC 20006). Such a forecast combined with the historical period data, will provide a price index for hospital inpatient reimbursement in the state.

The National Hospital Input Price Index was developed utilizing a fixed set of weights for each of seven (7) categories of expenses. The article by Freeland, et al., in the HCFA Review (Summer 1979) discussed the various "market basket" comparisons, input-output data, and other survey designs which were utilized in the establishment of the Price Index. These were further refined by Data Resources, Inc., to provide a total of fourteen (14) basic Expense Categories. Relative cost weights were established from 1977 data to establish the final National Market Basket Price Proxies published in Health Care Costs (Data Resources, Inc., Vol. 1, No. 1, May 1981). This publication will provide market basket forecasts for a total of sixteen (16) quarters in order to permit a detailed analysis of the basic input categories of goods and services purchased by a hospital or provided to employees through wages and benefits.

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

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 the uninsured

1. Calculation of Interim Disproportionate Share Hospital (DSH) Limit: A base year will be used to calculate the cost of the uninsured and Medicaid eligible beneficiaries. The base year will be the State fiscal year with the most recent DSH audit being completed. 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.

   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 hospital covered charges will be multiplied by the CCR to determine Medicaid cost. All payments made related to these Medicaid hospital covered charges would be used to offset the Medicaid cost to determine uncompensated Medicaid hospital cost.

c. The inpatient and outpatient hospital 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 hospital services for individuals with no source of third party insurance will be combined with the uncompensated Medicaid hospital cost to determine the uncompensated care cost. Any Medicaid hospital payments in excess of Medicaid hospital 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 by applying the Global Insight Health-Care Cost Review from the mid-point of the cost reporting fiscal year to the mid-point of the next State Fiscal Year and then from mid-point of the State fiscal year to the mid-point of the current State Fiscal Year.

2. 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 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.

Each hospital will supply the State with covered detailed days and covered charges information for services provided to Medicaid eligible individuals paid through the Alabama Medicaid Management Information System 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 hospital cost of services for inpatient routine care services, inpatient ancillary services, and outpatient ancillary services will be determined in accordance with the DSH final rule published on December 19, 2008 and the CMS General DSH Audit Reporting Protocol 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.
Medicaid FFS Medicaid Eligible Outpatient Ancillary Cost for Acute and Sub-Provider Services	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. For each organ type, Total Organ Acquisition cost per Worksheet D-4 Part III Line 60 Column 1 will be divided by Total Usable Organs per Worksheet D-4 Part III Line 61 Column 1 to determine the cost per organ for each organ type. The cost per organ for each organ type will be multiplied by the number of organs transplanted obtained from the State's MMIS system for Alabama Fee for Service and from the hospital's internal records for Medicaid Managed Care and Medicaid Out Of State services. Medicare/Medicaid Dual Eligibles individuals will not be included as the amount for Medicaid Services would be offset by the amount reimbursed by Medicare Services.

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 less the payments received for CRNA 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 hospital services provided to individuals with no source of third party insurance shall be calculated as follows:

a. The cost of hospital services for inpatient routine care services, inpatient ancillary services, outpatient ancillary services, and transplant services will be determined in accordance with the DSH final rule published on December 19, 2008 and the CMS General DSHA Audit Reporting Protocol 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 23 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.

b. For each organ type, Total Organ Acquisition cost per Worksheet D-4 Part III Line 60 Column 1 will be divided by Total Usable Organs per Worksheet D-4 Part III Line 61 Column 1 to determine the cost per organ for each organ type. The cost per organ for each organ type will be multiplied by the number of organs transplanted obtained from the hospital's internal records for individuals with no source of third party insurance.

c. Combining the cost of uninsured routine services, cost of uninsured inpatient ancillary services, cost of uninsured outpatient ancillary services, the cost of uninsured organ acquisition costs plus the Medicaid portion of CRNA expense removed on Worksheet A-8 based on the uninsured utilization of uninsured charges divided by total charges 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 hospital services for individuals with no source of third party insurance will be combined with the uncompensated cost of care for hospital 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 hospital 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.

e. 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.

If necessary, each hospital will supply the State with updated covered detailed days and covered charges information for services provided to Medicaid eligible individuals paid through the Alabama Medicaid Management Information System 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 in accordance with the DSH final rule published on December 19, 2008 and the CMS General DSH Audit Reporting Protocol 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 23 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.
Medicaid FFS Medicaid Eligible Routine Service Cost For Sub-Provider Services	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.
Medicaid FFS Medicaid Eligible Routine Service Cost For Sub-Provider Services	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.
Medicaid FFS Medicaid Eligible Inpatient Ancillary Cost for Acute and Sub-Provider Services	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.
Medicaid FFS Medicaid Eligible Outpatient Ancillary Cost for Acute and Sub-Provider Services	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. For each organ type, Total Organ Acquisition cost per Worksheet D-4 Part III Line 60 Column 1 will be divided by Total Usable Organs per Worksheet D-4 Part III Line 61 Column 1 to determine the cost per organ for each organ type. The cost per organ for each organ type will be multiplied by the number of organs transplanted obtained from the State's MMIS system for Alabama Fee for Service and from the hospital's internal records for Medicaid Managed Care and Medicaid Out Of State services. Medicare/Medicaid Dual Eligibles individuals will not be included as the amount for Medicaid Services would be offset by the amount reimbursed by Medicare Services.

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 less the payments received for CRNA services will represent the cost of Medicaid eligible hospital services.

d. The payments received related to Medicaid hospital 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 hospital services provided to individuals with no source of third party insurance shall be calculated as follows:

a. The cost of hospital services for inpatient routine care services, inpatient ancillary services, outpatient ancillary services, and transplant services will be determined in accordance with the DSH final rule published on December 19, 2008 and the CMS General DSH Audit Reporting Protocol 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 23 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. For each organ type, Total Organ Acquisition cost per Worksheet D-4 Part III Line 60 Column 1 will be divided by Total Usable Organs per Worksheet D-4 Part III Line 61 Column 1 to determine the cost per organ for each organ type. The cost per organ for each organ type will be multiplied by the number of organs transplanted obtained from the hospital's internal records for individuals with no source of third party insurance.

c. Combining the cost of uninsured routine services, cost of uninsured inpatient ancillary services, cost of uninsured outpatient ancillary services, the cost of uninsured organ acquisition 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 to determine the total cost of hospital 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 hospital 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 of hospital services. Any Medicaid payments in excess of Medicaid cost will be used to offset uncompensated care of hospital 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.

Listing of Inpatient Access Payments and Disproportionate Share Hospital Payments

Inpatient access payments and DSH payments distributed to individual hospitals include consideration of the following factors; Hospital Cost, OBRA limits, hospital charges, overall UPL GAP by hospital category, and other special circumstances. The payments for each hospital are noted below for rate year 2014.

Inpatient Access Payments for the State Fiscal Year Ended September 30, 2014

State Owned and Operated Hospitals

Facility	Inpatient Access Payments
UNIVERSITY OF ALABAMA	59,707,266
USA CHILDRENS & WOMENS HOSPITAL	8,932,741
USA MEDICAL CTR HOSP	24,344,371
Total State Owned and Operated Hospitals	92,984,378

Non-State Government Owned and Operated Hospitals

Facility	Inpatient Access Payments
ATHENS LIMESTONE HOSP	2,790,129
GULF HEALTH HOSPITALS DBA THOMAS HOSPITAL	322,014
BAPTIST MEDICAL CENTER EAST	9,176,040
BAPTIST MEDICAL CTR SOUTH	24,437,969
BIBB MEDICAL CENTER HOSPITAL	1,217,948
BRYAN W WHITFIELD MEMORIAL H	1,946,778
CALLAHAN EYE FOUNDATION HOSPITAL	4,402
COOSA VALLEY MEDICAL CENTER	1,810,995
CULLMAN REG MEDICAL CENTER	2,401,431
D.W. MCMILLAN MEMORIAL HOSPITAL	69,431
DALE MEDICAL CENTER	341,132
DCH REGIONAL MEDICAL CENTER	8,382,898
DECATUR GENERAL HOSPITAL	2,490,010
EAST AL MEDICAL CENTER	4,469,272

Facility	Inpatient Access Payments
ECACH INC/ATMORE COMMUNITY H	219,480
GREENE COUNTY HOSPITAL	1,145,673
GROVE HILL MEMORIAL HOSPITAL	915,665
HALE COUNTY HOSPITAL	105,630
HELEN KELLER HOSPITAL	1,905,966
HIGHLANDS MEDICAL CENTER	694,160
HILL HOSPITAL OF SUMTER COUN	654,699
HUNTSVILLE HOSPITAL	9,964,993
JPAUL JONES HOSPITAL	1,379,061
LAWRENCE MEDICAL CENTER	251,433
MARSHALL MEDICAL CENTER SOUT	2,640,614
MEDICAL CENTER BARBOUR	1,830,240
MEDICAL WEST	4,016,017
MONROE COUTNY HOSPITAL	936,472
NORTH BALDWIN INFIRMARY	601,205
NORTHEAST AL REGIONAL MED CT	4,378,541
PARKWAY MEDICAL CENTER	2,416,292
PICKENS COUNTY MEDICAL CTR	711,832
PRATTVILLE BAPTIST HOSPITAL	539,682
RED BAY HOSPITAL	77,885
SOUTHEAST ALABMAM MED CTR	4,661,216
TROY REGIONAL MEDICAL CENTER	1,626,880
WASHINGTON COUTNY HOSPITAL	2,490
WEDOWEE HOSPITAL	183,136
WIREGRASS MEDICAL CENTER	547,613
Total Non-State Government Owned and Operated Hospitals	102,267,324

Privately Owned and Operated Hospitals

Facility	Inpatient Access Payments
ANDALUSIA REGIONAL HOSPITAL	3,990,633
BULLOCK COUTNY HOSPITAL	1,689,107
CHOCTAW COMMUNITY HOSPITAL	394,702
CITIZENS BAPTIST MEDICAL CTR	7,913,736
COMMUNITY HOSPITAL	2,391,836
EVERGREEN MEDICAL CENTER	1,436,994
FLORALA MEMORIAL HOSPITAL	86,576
FLOWERS HOSPITAL	11,643,691
GEORGIANA HOSPTIAL	725,321
HEALTHSOUTHLAKESHORE HOSPITAL	76,319
JACK HUGHSTON MEMORIAL HOSPITAL	1,036,368
JACKSON HOSPITAL & CLINIC	13,106,429
LAKE MARTIN COMMUNITY HOSPITAL	766,445
LV STABLER MEMORIAL HOSPITAL	1,153,425
MOBILE INFIRMARY	26,587,178
NORTHWEST MEDICAL CENTER	2,655,614
RIVERVIEW REGIONAL MED CTR	9,481,887
RUSSELL HOSPITAL	5,580,241
SHOALS HOSPITAL	2,484,355
SPRINGHILL MEM HOSP	4,327,767
ST VINCENTS EAST	11,614,723
THE CHILDRENS HOSPITAL OF ALABAMA	84,970,068
TRINITY MEDICAL CENTER	12,015,100
WALKER BAPTIST MEDICAL CENTE	11,766,024
PROFESSIONAL RESOURCES MANAGEMENT PSYCHIATRIC SERV **X**	1,265,690
LAUREL OAKS BEHAVIORAL HEALTH CEN **X**	1,404,023
MOUNTAIN VIEW HOSPITAL **X**	1,080,702
HILL CREST BEHAVIORAL HLTH S **X**	1,924,132
BAYPOINTE BEHAVIORAL HEALTH **X**	975,772
Total Privately Owned and Operated Hospitals	224,544,858

X - Privately owned and operated psychiatric hospitals

Privately Owned or Operated Disproportionate Share Hospitals

Facility	DSH Payments
BAPTIST MED CENTER – PRINCET	17,584,820
BROOKWOOD MEDICAL CENTER	9,638,674
CHEROKEE MEDICAL CENTER	1,781,512
CRENSHAW COMMUNITY HOSPITAL	1,678,193
CRESTWOOD MEDICAL CENTER	6,955,069
DEKALB REGIONAL MEDICAL CENTER	5,122,720
ELIZA COFFEE MEMORIAL HOSPIT	13,554,240
ELMORE COMMUNITY HOSPITAL	815,865
FLORALA MEMORIAL HOSPITAL	220,398
GADSDEN REGIONAL MEDICAL CTR	13,738,710
GEORGE H LANIER MEMORIAL HOS	3,050,666
JACKSON MEDICAL CENTER	1,626,969
LAKELAND COMMUNITY HOSPITAL	2,250,346
MARION REGIONALMEDICAL CENTE	1,434,038
MIZELL MEMORIAL HOSPITAL	1,611,782
PROVIDENCE HOSPITAL	13,405,106
QHG OF ENTERPRISE INC	4,862,051
RUSSELLVILLE HOSPITAL	6,424,464
SHELBY BAPTIST MEDICAL CENTE	14,810,456
SOUTH BALDWIN REGIONAL MED C	5,761,895
SPRINGHILL MEM HOSP	1,717,510
ST VINCENTS BLOUNT	2,581,742
ST VINCENTS EAST	739,894
ST VINCENTS HOSPITAL	9,216,258
ST VINCENTS ST CLAIR	2,121,849
STRINGFELLOW MEM HOSP	4,811,552
TRINITY MEDICAL CENTER	785,561
VAUGHAN REG MED CTR PARKWAY CAMPU	9,461,712

NOTE: State owned and operated hospitals and non-State government owned and operated hospitals initial DSH payments will be determined with the CPE estimate in Exhibit C of this attachment and final payments will be determined through the DSH audit process and the CPE reconciliations in Exhibit C of this attachment.