

**ITEM 14 OF THE SPECIAL TERMS AND CONDITIONS
FUNDING AND REIMBURSEMENT PROTOCOL**

The State must modify this protocol as well as any portion of the approved Medicaid State Plan that utilizes certified public expenditures (CPEs) to reflect any changes in CPE regulations or policy that CMS may release.

Summary of Medi-Cal 2552-96 Cost Report and Step-Down Process

Worksheet A

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

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

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

Worksheet B

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

Worksheet C

Computation of the cost-to-charge ratio for each cost center. The total cost for each cost center is derived from Worksheet B, after the overhead allocation. The total charge for each cost center is determined from the provider's records. The cost-to-charge ratios are used in the Worksheet D series (see the apportionment process of ancillary and other non-routine cost centers).

Worksheet D

This series (including D-1) is where the total costs from Worksheet B are apportioned to different payer programs. Apportionment is the process by which a cost center's total cost is allocated to a specific payer or program or service type. For example, an apportionment is used to arrive at Medicare hospital inpatient routine and ancillary cost, Medicare hospital outpatient cost, as well as Medicaid hospital inpatient routine and ancillary cost, and Medicaid hospital outpatient cost, etc.

- (i) Under the apportionment process for each routine service cost center, a per diem is computed by dividing the cost center's reimbursable cost by the cost center's total patient

days. The resulting per diem is multiplied by the number of program days to arrive at program cost.

(ii) Under the apportionment process for each ancillary/outpatient /other non-routine reimbursable cost center, the cost-to-charge ratio from Worksheet C for each cost center is multiplied by the program charge for that cost center to arrive at program cost.

Worksheet E

This series contains the settlement worksheets that compute actual reimbursement and account for interim payments. The Medicaid costs computed from the Worksheet D series are transferred to Worksheet E-3, Part III (Title 19) for Medicaid.

NOTES:

(i) States making CPE-funded payments for non-hospital-based costs under section 1115(a)(2) waiver authority, must develop/identify a separate cost reporting tool and receive CMS approval for such cost reporting prior to claims for Federal matching funds.

(ii) For purposes of utilizing the Medi-Cal 2552-96 cost report to determine Medicaid reimbursements described in the subsequent instructions, the following terms are defined:

The term "finalized Medi-Cal 2552-96 cost report" refers to the cost report that is settled by the California Department of Health Services (DHS), Audits and Investigations (A&I) with the issuance of a Report On The Cost Report Review (Audit Report).

The term "filed Medi-Cal 2552-96 cost report" refers to the cost report that is submitted by the hospital to A&I and is due 5 months after the end of the cost reporting period.

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

(iii) Los Angeles County hospitals (to the extent that they, as all-inclusive-charge-structure hospitals, have been approved by Medicare to use alternative statistics such as relative value units in the cost report apportionment process) may also use alternative statistics as a substitute for charges in the apportionment processes described in this document. These alternative statistics must be consistent with alternative statistics approved for Medicare cost reporting purposes and must be supported by auditable hospital documentation.

Certified Public Expenditures – Determination of Allowable Medicaid Hospital Costs

To determine a governmentally-operated hospital's allowable Medicaid costs and associated Medicaid reimbursements when such costs are funded by a State through the certified public expenditure (CPE) process, the following steps must be taken to ensure Federal financial participation:

Interim Medicaid Inpatient Hospital Payment Rate

The purpose of an interim Medicaid inpatient hospital payment rate is to provide an interim payment that will approximate the Medicaid inpatient hospital costs eligible for Federal financial participation claimed through the CPE process. This computation of establishing interim Medicaid inpatient hospital payment funded by CPEs must be performed on an annual basis and in a manner consistent with the instructions below.

1. The process of determining the allowable Medicaid inpatient hospital costs eligible for Federal financial participation (FFP) begins with the use of each governmentally-operated hospital's most recently filed Medi-Cal_2552-96 cost report for purposes of Medicaid reimbursement.
2. To determine the interim Medicaid payment rate, the State should use the most recently filed Medi-Cal 2552-96 cost report, follow the Medi-Cal 2552-96 cost report apportionment process as prescribed in the Worksheet D series to arrive at the total Medicaid non-psychiatric inpatient hospital cost.

On the Medi-Cal 2552-96 cost report, interns and residents costs should not be removed from total allowable costs on Worksheet B, Part I, column 26, since Medi-Cal does not separately reimburse for Graduate Medical Education costs via a per-resident amount methodology. If the costs have been removed, the State should add allowable interns and residents costs back to each affected cost center prior to the computation of cost-to-charge ratios on Worksheet C. This can be accomplished by using Worksheet B, Part I, column 25 (instead of column 27) for the Worksheet C computation of cost-to-charge ratios. The State is to only add back allowable interns and residents costs that are consistent with Medicare cost principles. If the hospital is a cost election hospital under the Medicare program, the costs of teaching physicians that are allowable as GME under Medicare cost principles shall be treated as hospital interns and residents costs consistent with non-cost election hospitals.

For hospitals that remove Medicaid inpatient dental services (through a non-reimbursable cost center or as an A-8 adjustment), the State will make necessary adjustments to Worksheet A trial balance cost (and, as part of the cost report flow, any other applicable Medi-Cal 2552-96 worksheets) to account for the Medicaid inpatient dental services identified in Attachment D to the Special Terms and Conditions. This is limited to allowable hospital inpatient costs and should not include any professional cost component.

Additionally, the State will perform those tests necessary to determine the reasonableness of the Medicaid program data (i.e., Medicaid days and Medicaid charges) from the reported Medi-Cal 2552-96 cost report's Worksheet D series. This will include reviewing the Medicaid program data generated from its MMIS/claims system for that period which corresponds to the most recently filed Medi-Cal 2552-96 cost report. However, because the MMIS/claims system data would generally not include all paid claims until 18 months after the Fiscal Year Ending (FYE) of the cost report, the State will take steps to verify the filed Medicaid program data, including the use of submitted Medicaid claims. Only Medicaid program data related to medical services that are eligible under the Medicaid inpatient hospital cost computation should be used in the apportionment process.

Medicaid payments that are made independent of the Medicaid inpatient hospital non-psychiatric per diem for Medicaid inpatient hospital services of which the costs are already included in the Medicaid inpatient hospital non-psychiatric cost computation described above, must be offset against the computed Medicaid non-psychiatric inpatient hospital cost before a per diem is computed in Step number 3 below.

3. The computed Medicaid non-psychiatric inpatient hospital cost computed in Step number 2 above should be divided by the number of Medicaid non-psychiatric inpatient hospital days as determined in Step number 2 above for that period which corresponds to the most recently filed Medi-Cal 2552-96 cost report.

4. The Medicaid per day amount computed in Step number 3 above can be trended to current year based on Market Basket update factor(s) or other hospital-related indices as approved by CMS. The Medicaid per day amount may be further adjusted to reflect increases and decreases in costs incurred resulting from changes in operations or circumstances as follows:

- (i) Inpatient hospital costs not reflected on the filed Medi-Cal 2552-96 cost report from which the interim payments are developed, but which would be incurred and reflected on the Medi-Cal 2552-96 cost report for the spending year.
- (ii) Inpatient hospital costs incurred and reflected on the filed Medi-Cal 2552-96 cost report from which the interim payments are developed, but which would not be incurred or reflected on the Medi-Cal 2552-96 cost report for the spending year.

Such costs must be properly documented by the hospital and subject to review by the State and CMS. The result is the Medicaid non-psychiatric inpatient hospital cost per day amount to be used for interim Medicaid inpatient hospital payment rate purposes.

5. An audit factor may be applied to the filed Medi-Cal 2552-96 cost report to adjust computed cost by the average percentage change from total reported costs to final costs for the three most recent Medi-Cal 2552-96 cost reporting periods for which final determinations have been made. Such percentage must be identified to CMS.

Interim Reconciliation of Interim Medicaid Inpatient Hospital Payment Rate

Each governmentally-operated hospital's interim Medicaid payments will be reconciled to its filed Medi-Cal 2552-96 cost report for the spending year in which interim payments were made. If, at the end of the interim reconciliation process, it is determined that a hospital received an overpayment, the overpayment will be properly credited to the federal government.

The State will adjust the cost used in the Worksheet C computation by adding back allowable interns and residents costs to the appropriate cost centers as explained in Step number 2 in the Interim Medicaid Inpatient Hospital Payment Rate section of this document. The State will also adjust the cost for inpatient dental as explained in Step 2 for those hospitals that used such adjustment to create the interim Medicaid payment rate.

In computing the Medicaid non-psychiatric inpatient hospital cost on the most recently filed Medi-Cal 2552-96 cost report, the State should update the Medicaid program data (such as Medicaid days and charges) on the cost report worksheet D series with Medicaid program data generated -from its MMIS/claims system for the respective cost reporting period. As explained in Step number 2 in the Interim Medicaid Inpatient Hospital Payment Rate section of this document, data generated from the MMIS/claims system will not be complete, and steps to verify the data will be taken by the State including the use of submitted Medicaid claims. Only Medicaid program data related to medical services that are eligible under the Medicaid inpatient hospital cost computation should be used in the apportionment process.

Medicaid payments that are made independent of the Medicaid inpatient hospital non-psychiatric per diem for Medicaid inpatient hospital services of which the costs are already included in the Medicaid inpatient hospital non-psychiatric cost computation described above, must be included in the total Medicaid payments (along with the interim Medicaid payments based on the Medicaid non-psychiatric inpatient hospital per diem) under this interim reconciliation process. Adjustments made to the MMIS data mentioned above may address outstanding Medicaid claims for which the hospital has not received payment. The State will take steps to ensure that payments associated with the pending claims, when paid, for Medicaid costs included in the current spending year cost report are properly accounted.

An audit factor may be applied to the filed Medi-Cal 2552-96 cost report to adjust computed cost by the average percentage change from total reported costs to final costs for the three most recent Medi-Cal 2552-96 cost reporting periods for which final determinations have been made. Such percentage must be identified to CMS.

Final Reconciliation of Interim Medicaid Inpatient Hospital Payment Rate

Each governmentally-operated hospital's interim payments and interim adjustments in a spending year will also be subsequently reconciled to its Medi-Cal 2552-96 cost report

for that same spending year as finalized by A&I for purposes of Medicaid reimbursement. If, at the end of the final reconciliation process, it is determined that a hospital received an overpayment, the overpayment will be properly credited to the federal government.

The State will adjust the cost used in the Worksheet C computation by adding back allowable interns and residents costs to the appropriate cost centers as explained in Step number 2 in the Interim Medicaid Inpatient Hospital Payment Rate section of this document. The State will also adjust the cost for inpatient dental as explained in Step 2 for those hospitals that used such adjustment to create the interim Medicaid payment rate.

In computing the Medicaid non-psychiatric inpatient hospital cost from the finalized Medi-Cal 2552-96 cost report, the State should update the Medicaid program data (such as Medicaid days and charges) on the finalized cost report Worksheet D series with Medicaid program data generated from its MMIS/claims system for the respective cost reporting period. Only Medicaid program data related to medical services that are eligible under the Medicaid inpatient hospital cost computation should be used in the apportionment process.

Medicaid payments that are made independent of the Medicaid inpatient hospital non-psychiatric per diem for Medicaid inpatient hospital services of which the costs are already included in the Medicaid inpatient hospital non-psychiatric cost computation described above, must be included in the total Medicaid payments (along with the interim Medicaid payments based on the Medicaid non-psychiatric inpatient hospital per diem) under this final reconciliation process.

Certified Public Expenditures – Determination of Allowable Safety Net and DSH Costs

To determine a governmentally-operated hospital's allowable Safety Net Care Pool (SNCP) costs and the associated SNCP reimbursements and to determine a hospital's allowable uncompensated care costs eligible for disproportionate share hospital (DSH) reimbursement when such costs are funded by a State through the certified public expenditure (CPE) process, the following steps must be taken to ensure Federal financial participation:

Safety Net Care Pool (SNCP) Payments

The purpose of interim SNCP payments is to provide an interim payment that will approximate the SNCP costs eligible for Federal financial participation claimed through the CPE process. This computation of establishing interim SNCP payments funded by CPEs must be performed on an annual basis and in a manner consistent with the instruction below.

1. The process of determining the allowable SNCP costs eligible for Federal financial participation (FFP) begins with the use of each governmentally-operated hospital most recently filed Medi-Cal 2552-96 cost report for purposes of Medicaid reimbursement.
2. The total allowable SNCP hospital cost should be computed by using the most recently filed Medi-Cal 2552-96 cost report.

The State will make necessary adjustments to Worksheet A trial balance cost (and, as part of the cost report flow, any other applicable Medi-Cal 2552-96 worksheets) to account for the SNCP cost elements identified in Attachment D to the Special Terms and Conditions.

As discussed in the Interim Medicaid Inpatient Hospital Payment Rate section of this document, the State will adjust the cost used in the Worksheet C computation by adding back allowable interns and residents' costs to the appropriate cost centers.

In the cost report apportionment process in Worksheet D series, auditable uninsured program data (days and charges) will be used to determine uninsured hospital cost. This data will be submitted to the State by the hospitals based on data from the hospital's records. Only program data for medical services eligible for SNCP should be included in the apportionment process in the Worksheet D series. Though not part of the standard Medi-Cal 2552, this information provided to the State is subject to the same audit standards and procedures as the data included in the Medi-Cal 2552 cost report.

The costs described in this document eligible under the SNCP relate strictly to individuals with no source of third party insurance coverage for the inpatient and outpatient hospital services they receive that would have been benefits eligible for federal reimbursement under Title XIX had these individuals been eligible Medi-Cal

beneficiaries, and those costs identified in Attachment D of the Special Terms and Conditions. The determination of other costs eligible for SNCP funding (e.g., clinic costs, medical care costs incurred by the State or counties) will be addressed in a separate methodology within the protocol document.

The program data should be for the period which corresponds to the most recently filed Medi-Cal 2552-96 cost report.

Any SNCP-eligible cost that is not reported on the hospital cost report or that the State believes should not be subject to the cost report apportionment process must be identified separately to and approved by CMS.

Any self-pay payments made by or on behalf of uninsured patients to the hospital for services of which the costs are already included in the SNCP cost computation described above should be offset against the computed SNCP-eligible costs. For purposes of the preceding sentence, payments and other funding and subsidies made by a state or a unit of local government (e.g., state-only, local-only, or joint state-local health programs) to a hospital for inpatient and outpatient services provided to indigent patients shall not be considered a source of third party payment.

3. The net SNCP cost computed above can be trended to current year based on Market Basket update factor(s) or other hospital-related indices as approved by CMS. The net SNCP costs may be further adjusted to reflect increases or decreases in costs incurred resulting from changes in operations or circumstances as follows:

- (i) Inpatient and outpatient hospital costs not reflected on the filed Medi-Cal 2552-96 cost report from which the interim payments are developed, but which would be incurred and reflected on the Medi-Cal 2552-96 cost report for the spending year.
- (ii) Inpatient and outpatient hospital costs incurred and reflected on the filed Medi-Cal 2552-96 cost report from which the interim payments are developed, but which would not be incurred or reflected on the Medi-Cal 2552-96 cost report for the spending year.

Such costs must be properly documented by the hospital and are subject to review by the State and CMS.

4. The total SNCP certifiable expenditures as computed above should be reduced by 17.79% to account for non-emergency care furnished to unqualified aliens. The costs of non-emergency care furnished to unqualified aliens are eligible for federal matching funds under the DSH program only. Those costs that are limited to SNCP funding in Attachment D are not eligible for federal matching funds under the DSH program.

5. The State will identify that portion of the SNCP certifiable expenditures computed above that is also eligible as Disproportionate Share Hospital costs. Annually, the State will separately identify to CMS:

- (i) Total inpatient and outpatient hospital costs eligible only for SNCP funded by SNCP payments;
- (ii) Total inpatient and outpatient hospital costs eligible for both DSH and SNCP funded by SNCP payments;
- (iii) Total inpatient and outpatient hospital costs eligible for both DSH and SNCP funded by DSH payments
- (iv) Total inpatient and outpatient hospital costs eligible only for DSH funded by DSH payments;
- (v) Total non-hospital costs funded by SNCP payments.

An audit factor may be applied to the filed Medi-Cal 2552-96 cost report to adjust computed cost by the average percentage change from total reported costs to final costs for the three most recent Medi-Cal 2552-96 cost reporting periods for which final determinations have been made. Such percentage must be identified to CMS.

6. Interim SNCP payments can be made based on the SNCP certifiable expenditures as computed above. The interim payments can be on a quarterly or other periodic basis approved by CMS. There will be no duplication of claiming with respect to costs as SNCP certifiable expenditures and DSH certifiable expenditures.

Interim Reconciliation of Interim SNCP Payments

Each governmentally-operated hospital's interim SNCP certifiable expenditures will be reconciled based on its filed Medi-Cal 2552-96 cost report for the spending year in which interim payments were made. The State will adjust, as necessary, the aggregate amount of interim SNCP funds claimed based on the total SNCP certifiable expenditures determined under the interim reconciliations. If, at the end of the interim reconciliation process, it is determined that SNCP funding was over-claimed, the overpayment will be properly credited to the federal government.

The State will make necessary adjustments to Worksheet A trial balance cost (and, as part of the cost report flow, any other applicable Medi-Cal 2552-96 worksheet) to account for the SNCP cost elements (Attachment D to the Special Terms and Conditions).

As discussed in the Interim Medicaid Inpatient Hospital Payment Rate section of this document, the State will adjust the cost used in the Worksheet C computation by adding back allowable interns and residents' costs to the appropriate cost centers.

Also, in computing the uninsured hospital cost on the most recently filed Medi-Cal 2552-96 cost report, the State should use auditable uninsured program data (such as days and charges) for the Worksheet D series apportionment process. Only program data for medical services eligible for SNCP should be included in the apportionment process in Worksheet D series. Though not part of the standard Medi-Cal 2552, this information provided to the State is subject to the same audit standards and procedures as the data included in the Medi-Cal 2552 cost report.

Any self-pay payments made by or on behalf of uninsured patients to the hospitals for services of which costs are included in the SNCP cost computation described above should be offset against the computed SNCP costs under the interim reconciliation process. For purposes of the preceding sentence, payments and other funding and subsidies made by a state or a unit of local government (e.g., state-only, local-only or joint state-local health programs) to a hospital for inpatient and outpatient services provided to indigent patients shall not be considered a source of third party payment.

The total SNCP certifiable expenditures as computed above should be reduced by 17.79% to account for non-emergency care furnished to unqualified aliens. The costs of non-emergency care furnished to unqualified aliens are eligible for federal matching funds under the DSH program only. Those costs that are limited to SNCP funding in Attachment D are not eligible for federal matching funds under the DSH program.

The State will identify that portion of the SNCP certifiable expenditures computed above that is also eligible as Disproportionate Share Hospital costs. Annually, the State will separately identify to CMS:

- (i) Total inpatient and outpatient hospital costs eligible only for SNCP funded by SNCP payments;
- (ii) Total inpatient and outpatient hospital costs eligible for both DSH and SNCP funded by SNCP payments;
- (iii) Total inpatient and outpatient hospital costs eligible for both DSH and SNCP funded by DSH payments;
- (iv) Total inpatient and outpatient hospital costs eligible only for DSH funded by DSH payments;
- (v) Total non-hospital costs funded by SNCP payments.

There will be no duplication of claiming with respect to costs as SNCP certifiable expenditures and DSH certifiable expenditures.

An audit factor may be applied to the filed Medi-Cal 2552-96 cost report to adjust computed cost by the average percentage change from total reported costs to final costs for the three most recent Medi-Cal 2552-96 cost reporting periods for which final determinations have been made. Such percentage must be identified to CMS.

Final Reconciliation of Interim SNCP Payments

Each governmentally-operated hospital's interim SNCP certifiable expenditures (and any interim adjustments) will also subsequently be reconciled based on its Medi-Cal 2552-96 cost report as finalized by A&I for purposes of Medicaid reimbursement for the respective cost reporting period. The State will adjust, as necessary, the aggregate amount of interim SNCP funds claimed based on the total certifiable SNCP expenditures determined under the final reconciliations. If, at the end of the final reconciliation process, it is determined that SNCP funding was over-claimed, the overpayment will be properly credited to the federal government.

The State will make necessary adjustments to Worksheet A trial balance cost (and, as part of the cost report flow, any other applicable Medi-Cal 2552-96 worksheet) to account for the SNCP cost elements (Attachment D to the Special Terms and Conditions).

As discussed in the Interim Medicaid Inpatient Hospital Payment Rate section of this document, the State will adjust the cost used in the Worksheet C computation by adding back allowable interns and residents' costs to the appropriate cost centers.

Also, in computing the uninsured hospital cost on the finalized Medi-Cal 2552-96 cost report, the State should use auditable uninsured program data (such as days and charges) for the Worksheet D series apportionment process. Only program data for medical services eligible for SNCP should be included in the apportionment process in Worksheet D series. Though not part of the standard Medi-Cal 2552, this information provided to the State is subject to the same audit standards and procedures as the data included in the Medi-Cal 2552 cost report.

Any self-pay payments made by or on behalf of uninsured patients to the hospitals for services of which costs are included in the SNCP cost computation described above should be offset against the computed SNCP costs under this final reconciliation process. For purposes of the preceding sentence, payments and other funding and subsidies made by a state or a unit of local government (e.g., state-only, local-only, or joint state-local health programs) to a hospital for inpatient and outpatient services provided to indigent patients shall not be considered a source of third party payment.

The total SNCP certifiable expenditures as computed above should be reduced by 17.79% to account for non-emergency care furnished to unqualified aliens. The costs of non-emergency care furnished to unqualified aliens are eligible for federal matching funds under the DSH program only. Those costs that are limited to SNCP funding in Attachment D are not eligible for federal matching funds under the DSH program.

The State will identify that portion of the SNCP certifiable expenditures computed above that is also eligible as Disproportionate Share Hospital costs. Annually, the State will separately identify to CMS:

- (i) Total inpatient and outpatient hospital costs eligible only for SNCP funded by SNCP payments;
- (ii) Total inpatient and outpatient hospital costs eligible for both DSH and SNCP funded by SNCP payments;
- (iii) Total inpatient and outpatient hospital costs eligible for both DSH and SNCP funded by DSH payments;
- (iv) Total inpatient and outpatient hospital costs eligible only for DSH funded by DSH payments;
- (v) Total non-hospital costs funded by SNCP payments.

There will be no duplication of claiming with respect to costs as SNCP certifiable expenditures and DSH certifiable expenditures.

Disproportionate Share Hospital (DSH) Payments

The purpose of an interim DSH payment is to provide an interim payment that will approximate the Medicaid and uninsured inpatient hospital and outpatient hospital uncompensated care costs (“shortfall”) eligible for Federal financial participation claimed through the CPE process. 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.

1. The process of determining the allowable DSH costs eligible for Federal financial participation (FFP) begins with the use of each governmentally-operated hospital's most recently filed Medi-Cal 2552-96 cost report for purposes of Medicaid reimbursement.
2. The total Medicaid managed care and Medicaid psychiatric inpatient and outpatient hospital shortfall and the uninsured hospital inpatient and outpatient costs should be computed by using the most recently filed Medi-Cal 2552-96 cost report.¹

As discussed in the Interim Medicaid Inpatient Hospital Payment Rate section of this document, the State will adjust the cost used in the Worksheet C computation by adding back allowable interns and residents’ costs to the appropriate cost centers. The State will also adjust the cost for inpatient dental as explained in Step 2 of the Interim Medicaid Inpatient Hospital Payment Rate section for those hospitals that used such adjustment to create the interim Medicaid payment rate and as identified in Attachment D to the Terms and Conditions.

In the cost report apportionment process in the Worksheet D series, auditable Medicaid managed care, Medicaid psychiatric, and uninsured program data (days and charges) will be used to compute the hospital's eligible DSH cost. This data will be submitted to the State. Only hospital inpatient and outpatient program data for medical services eligible for DSH should be included in the apportionment process in Worksheet D series. The program data should be from the period which corresponds to the most recently filed Medi-Cal cost report. Though not part of the standard Medi-Cal 2552, this information provided to the State is subject to the same audit standards and procedures as the data included in the Medi-Cal 2552 cost report.

Uninsured individuals are individuals with no source of third party insurance coverage for the inpatient hospital and outpatient hospital services they receive and as defined in governing federal statute and regulation.

3. All applicable Medicaid inpatient and outpatient hospital revenues, all SNCP payments claimed with respect to the hospital’s expenditures for the provision of inpatient and outpatient hospital services (i.e. the DSH eligible costs claimed for SNCP

¹ No shortfall related to fee-for-service Medicaid inpatient hospital and /or Medicaid outpatient hospital services is anticipated based on the certification of public expenditures up to total Medicaid inpatient and Medicaid outpatient hospital costs.

payments) and any self-pay payments made by or on behalf of uninsured patients for such services, must be offset against the computed cost from Step number 2 above to arrive at the eligible DSH expenditure. Payments, funding and subsidies made by a state or a unit of local government shall not be offset (e.g., state-only, local-only or state-local health programs). Using CPEs as a funding source, federal matching funds for DSH payments may be claimed up to the hospital's eligible uncompensated costs as determined in this process. Notwithstanding all of the foregoing, for purposes of calculating a hospital's 175% DSH limit only, SNCP payments claimed for the hospital's DSH eligible costs will not be counted as revenue offsets during Demonstration years one and two.

4. The net DSH cost computed above can be trended to current year based on Market Basket update factor(s) or other hospital-related indices as approved by CMS. The net DSH costs may be further adjusted to reflect increases or decreases in costs incurred resulting from changes in operations or circumstances as follows:

- (i) Inpatient and outpatient hospital costs not reflected in the filed Medi-Cal 2552-96 cost report from which the interim payments are developed, but which would be incurred and reflected on the Medi-Cal 2552-96 cost report for the spending year.
- (ii) Inpatient and outpatient hospital costs incurred and reflected in the filed Medi-Cal 2552-96 cost report from which the interim payments are developed, but which would not be incurred or reflected on the Medi-Cal 2552-96 cost report for the spending year.

Such costs must be properly documented by the hospital and are subject to review by the State and CMS.

An audit factor may be applied to the filed Medi-Cal 2552-96 cost report to adjust computed cost by the average percentage change from total reported costs to final costs for the three most recent Medi-Cal 2552-96 cost reporting periods for which final determinations have been made. Such percentage must be identified to CMS.

5. The State will identify that portion of the certifiable DSH expenditures computed above that is also eligible as SNCP costs (a maximum of 82.21% of the hospital uninsured costs). The State will identify that portion of the SNCP certifiable expenditures computed above that is also eligible as Disproportionate Share Hospital costs. Annually, the State will separately identify to CMS:

- (i) Total inpatient and outpatient hospital costs eligible only for SNCP funded by SNCP payments;
- (ii) Total inpatient and outpatient hospital costs eligible for both DSH and SNCP funded by SNCP payments;
- (iii) Total inpatient and outpatient hospital costs eligible for both DSH and SNCP funded by DSH payments;
- (iv) inpatient and outpatient hospital costs eligible only for DSH funded by DSH payments;
- (v) Total non-hospital costs funded by SNCP payments.

6. Interim DSH payments can be made based on the eligible DSH expenditure computed above. The interim payments can be on a quarterly or other periodic basis, but such payments must account for all revenue offsets. There will be no duplication of claiming with respect to costs as SNCP certifiable expenditures and DSH certifiable expenditures.

Interim Reconciliation of Interim DSH Payments

Each governmentally-operated hospital's interim DSH certifiable expenditures will be reconciled based on its filed Medi-Cal 2552-96 cost report for the spending year in which interim payments were made. The State will adjust, as necessary, the aggregate amount of interim DSH funds claimed based on the total DSH certifiable expenditures determined under the interim reconciliations. If, at the end of the interim reconciliation process, it is determined that DSH funding was over-claimed, the overpayment will be properly credited to the federal government.

As discussed in the Interim Medicaid Inpatient Hospital Payment Rate section of this document, the State will adjust the cost used in the Worksheet C computation by adding back allowable interns and residents' costs to the appropriate cost centers. The State will also adjust the cost for inpatient dental as explained in Step 2 of the Interim Medicaid Inpatient Hospital Payment Rate section for those hospitals that used such adjustment to create the interim Medicaid payment rate and as identified in Attachment D to the Terms and Conditions.

In computing the Medicaid managed care and Medicaid psychiatric shortfall and the uninsured hospital inpatient and outpatient cost based on the most recently filed Medi-Cal 2552-96 cost report, the State should use auditable Medicaid managed care, Medicaid psychiatric and uninsured program data (days and charges) for the Worksheet D series apportionment process. Only hospital inpatient and outpatient program data for medical services eligible for DSH should be included in the apportionment process in the Worksheet D series. Though not part of the standard Medi-Cal 2552, this information provided to the State is subject to the same audit standards and procedures as the data included in the Medi-Cal 2552 cost report.

All applicable Medicaid inpatient and outpatient hospital revenues, all SNCP payments claimed with respect to the hospital's expenditures for the provision of inpatient and outpatient hospital services (i.e. the DSH eligible costs claimed for SNCP payments) and any self-pay payments made by or on behalf of uninsured patients for such services, must be offset against the computed cost to arrive at the eligible DSH expenditure. Payments, funding and subsidies made by a state or a unit of local government shall not be offset (e.g., state-only, local-only or state-local health programs). Using CPEs as a funding source, federal matching funds for DSH payments may be claimed up to the hospital's eligible uncompensated costs as determined in this process. Notwithstanding all of the foregoing, for purposes of calculating a hospital's 175% DSH limit only, SNCP payments claimed for the hospital's DSH eligible costs will not be counted as revenue offsets during Demonstration years one and two.

The State will identify that portion of the certifiable DSH expenditures computed above that is also eligible as SNCP costs (a maximum of 82.21% of the hospital uninsured costs). The State will identify that portion of the SNCP certifiable expenditures computed above that is also eligible as Disproportionate Share Hospital costs. Annually, the State will separately identify to CMS:

- (i) Total inpatient and outpatient hospital costs eligible only for SNCP funded by SNCP payments;
- (ii) Total inpatient and outpatient hospital costs eligible for both DSH and SNCP funded by SNCP payments;
- (iii) Total inpatient and outpatient hospital costs eligible for both DSH and SNCP funded by DSH payments;
- (iv) Total inpatient and outpatient hospital costs eligible only for DSH funded by DSH payments;
- (v) Total non-hospital costs funded by SNCP payments.

An audit factor may be applied to the filed Medi-Cal 2552-96 cost report to adjust computed cost by the average percentage change from total reported costs to final costs for the three most recent Medi-Cal 2552-96 cost reporting periods for which final determinations have been made. Such percentage must be identified to CMS.

Final Reconciliation of Interim DSH Payments

Each governmentally-operated hospital's interim DSH certifiable expenditures (and any interim adjustments) will subsequently be reconciled based on its Medi-Cal 2552-96 cost report as finalized by A&I for purposes of Medicaid reimbursement for the respective cost reporting period. The State will adjust, as necessary, the aggregate amount of interim DSH funds claimed based on the total DSH certifiable expenditures determined under the final reconciliations. If, at the end of the final reconciliation process, it is determined that DSH funding was over-claimed, the overpayment will be properly credited to the federal government.

As discussed in the Interim Medicaid Inpatient Hospital Payment Rate section of this document, the State will adjust the cost used in the Worksheet C computation by adding back allowable interns and resident's costs to the appropriate cost centers. The State will also adjust the cost for inpatient dental as explained in Step 2 of the Interim Medicaid Inpatient Hospital Payment Rate section for those hospitals that used such adjustment to create the interim Medicaid payment rate and as identified in Attachment D to the Terms and Conditions.

In computing the Medicaid managed care and Medicaid psychiatric shortfall and the uninsured hospital inpatient and outpatient cost based on the finalized Medi-Cal 2552-96 cost report, the State should use auditable Medicaid managed care, Medicaid psychiatric, and uninsured program data (days and charges) for the Worksheet D series apportionment process. Only hospital inpatient and outpatient program data for medical services eligible for DSH should be included in the apportionment process in Worksheet D series.

Though not part of the standard Medi-Cal 2552, this information provided to the State is subject to the same audit standards and procedures as the data included in the Medi-Cal 2552 cost report.

All applicable Medicaid inpatient and outpatient hospital revenues, all SNCP payments claimed with respect to the hospital's expenditures for the provision of inpatient and outpatient hospital services (i.e. the DSH eligible costs claimed for SNCP payments) and any self-pay payments made by or on behalf of uninsured patients for such services, must be offset against the computed cost to arrive at the eligible DSH expenditure. Payments, funding and subsidies made by a state or a unit of local government shall not be offset (e.g., state-only, local-only or state-local health programs). Using CPEs as a funding source, federal matching funds for DSH payments may be claimed up to the hospital's eligible uncompensated costs as determined in this process. Notwithstanding all of the foregoing, for purposes of calculating a hospital's 175% DSH limit only, SNCP payments claimed for the hospital's DSH eligible costs will not be counted as revenue offsets during Demonstration years one and two.

The State will identify that portion of the certifiable DSH expenditures computed above that is also eligible as SNCP costs (a maximum of 82.21% of the hospital uninsured costs). The State will identify that portion of the SNCP certifiable expenditures computed above that is also eligible as Disproportionate Share Hospital costs. Annually, the State will separately identify to CMS:

- (i) Total inpatient and outpatient hospital costs eligible only for SNCP funded by SNCP payments;
- (ii) Total inpatient and outpatient hospital costs eligible for both DSH and SNCP funded by SNCP payments;
- (iii) Total inpatient and outpatient hospital costs eligible for both DSH and SNCP funded by DSH payments;
- (iv) Total inpatient and outpatient hospital costs eligible only for DSH funded by DSH payments;
- (v) Total non-hospital costs funded by SNCP payments.

NOTES:

- (i) All disproportionate share hospital (DSH) payments, funded through certified public expenditures or otherwise, are subject to the State of California's aggregate DSH allotment.
- (ii) Based on the State of California's proposal to certify total Medicaid inpatient and outpatient hospital costs (non-managed care), there would be no fee-for-service Medicaid inpatient and/or outpatient hospital cost "shortfall" for purposes of the hospital-specific DSH limits.
- (iii) For California's DSH hospitals that qualify for 175% DSH payment under the Benefits, Improvements, and Protections Act of 2000, during waiver years one and two, for the specific purpose of computing 175% of the OBRA 1993 hospital-specific uncompensated care cost (UCC) limit, UCC is computed without an offset for Safety Net Care Pool (SNCP) claims made for the

uninsured. However, the combination of SNCP funds and DSH funds that are claimed will not exceed 175 percent of UCC (for those hospitals subject to the 175 percent authority), to ensure no duplication of claiming. For purposes of the preceding sentence, each hospital's SNCP certifiable expenditures (excluding costs that are ineligible for DSH claiming) that are actually used by the State for claiming SNCP funds shall be counted against the above hospital-specific claiming limits, rather than the amounts actually distributed to the hospital by the State.

- (iv) Claims that are based on CPEs of qualifying UCC (determined as described in this document) may be submitted for Federal reimbursement from a combination of SNCP and DSH funds, at the State's discretion. The State may also claim federal DSH funds with respect to DSH payments made to hospitals equivalent to costs between 100 and 175 percent of eligible UCC, regardless of whether the combined amount of DSH and SNCP funds have been claimed based on CPEs to 100 percent of the hospital's UCC, provided that 100 percent of UCC has been certified as actually expended. There will be no duplication of UCC claimed for SNCP and DSH reimbursement.