



**Massachusetts Executive Office of
Health and Human Services**
Office of Medicaid

**Uniform Medicaid and Uninsured
Uncompensated Care Cost & Charge Report (UCCR)**

Instructions: Cost Limit Calculation Period 2025

**11th Floor
One Ashburton Place
Boston, MA 02108**

Uniform Medicaid and Uninsured Uncompensated Care Cost & Charge Report (UCCR)

Instructions

Filing Requirements

The Massachusetts Executive Office of Health and Human Services (EOHHS) Office of Medicaid requires hospitals to submit cost, charge and patient day data via the Uniform Medicaid and Uninsured Uncompensated Care Cost & Charge Report (“UCCR”). This data is used to ensure compliance with Uncompensated Care Cost Limit Protocol approved by the Centers for Medicare and Medicaid Services (“CMS”) on December 11, 2013. In addition, EOHHS uses the data to calculate the preliminary payment amounts for certain supplemental payments.

Hospitals that are eligible to receive payments from the Safety Net Care Pool must file a report. This includes the following payments:

- Public Service Hospital Safety Net Care Payment
- Health Safety Net Trust Fund Safety Net Care Payment
- Institutions for Mental Disease (IMD)
- Special Population State-Owned Non-Acute Hospitals Operated by the Department of Public Health
- State-Owned Non-Acute Hospitals Operated by the Department of Mental Health
- Safety Net Provider Payments
- Safety Net Provider Payments Closeout Activities

Note that a hospital must file a UCCR if it has submitted claims to the HSN for the filing year or received other payments from the Safety Net Care Pool. If the hospital has submitted claims to the HSN but did not receive a payment because the shortfall allocation exceeded its payment amount, it must still file a report.

For each hospital fiscal year, the provider must submit two UCCRs (Interim and Final) as described below.

Interim UCCR: Hospitals must file an Interim UCCR based on information supplied on the hospital’s Medicare cost report (CMS 2552), as filed with the Medicare fiscal intermediary, and hospital records as described below.

Final UCCR: Hospitals must submit a Final UCCR based on an audited and settled Fiscal Year 2025 CMS-2552 report, within five months of receipt of the audited report.

Due Dates: Interim UCCRs must be submitted to the Executive Office of Health and Human Services (“EOHHS”) three months after the CMS-2552 is filed. Final UCCRs must be submitted three months after the CMS-2552 is settled.

- For the Fiscal Year Cost Limit Calculations, hospitals must submit Interim UCCRs on the following dates:

Fiscal Year End	UCCR Filing Due Date*
12/31	8/31
1/31	9/30
6/30	3/1
8/31	4/30
9/30	5/31

* Hospitals with hospital-based hospices that have cost reporting periods beginning on or after October 15th and ending on or after September 20th, have a UCCR filing due date of August 1st. The filing due date indicates an 8-month lag after the Fiscal Year end. However, if CMS extends the due date of the CMS-2552, then the UCCR filing due date is extended by a commensurate amount of time.

Payment Calculations and Reconciliation: Provider payments will be calculated pursuant to federally approved payment methodologies as detailed in Massachusetts’ Medicaid State Plan or 1115 Demonstration Waiver. Provider payments are calculated on an interim basis, based on projected data submitted by the hospital on the Interim UCCR, as reviewed by EOHHS. Payments are subject to interim and final reconciliations as described below.

The Commonwealth may recover provider overpayments as it determines necessary based on its interim and final reconciliations and availability of federal financial participation.

Submission Process

Upon completing the report, hospitals should:

1. Save the report with the file name in the following format:

UCCR_**[Medicare Provider Number]**_**[FYE]**

Example: UCCR_220099_FY25

2. Email the completed report to: costlimitprotocol@state.ma.us

Cover Sheet

Hospital Name: Select the filing hospital name from the drop-down list.

Medicare Provider Number: Enter the hospital's Medicare provider number. Do not report sub-provider numbers in this field.

Reporting Period From: Enter the beginning of the reporting fiscal year of the CMS-225 and UCCR.

Reporting Period To: Enter the end of the reporting fiscal year of the CMS-2552 and UCCR.

UCCR Version: Select "Interim" or "Final" from the drop down to indicate the UCCR version.

Contact Information: Provide the contact information for the person who EOHHS may contact with questions regarding this report.

Filing Date: Indicate the date the UCCR is filed.

Hospital Assessment: Enter the amount the hospital paid for the Hospital Assessment during the fiscal year, pursuant to 101 CMR 514.00: Hospital Assessment.
Also, indicate whether the hospital reported this amount as an expense on the CMS-2552.

Schedule A: Computation of MassHealth Fee-for-Service (FFS) Costs
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Note: *Hospitals should not add lines, delete lines, add columns, or delete columns.*

Column 1 – Costs Including Interns and Residents

Enter costs from the hospital's Medicare cost report (CMS 2552) Worksheet B, Part 1, column 24. This column includes costs that have already been reclassified, adjusted and stepped down through the A and B worksheet series and includes costs related to interns and residents.

Column 2 – Observation Cost Reclass and Post Stepdown Costs not included in Column 1

Costs related to observation beds should be reclassified from line 30 (Adults and Pediatrics) to line 92 (Observation Beds). Observation costs are derived from the CMS-2552, Worksheet C, Part I, Column 5, Line 92. Add post-step-down costs from Supplemental Worksheet B-2, Column 4, Lines 54, 60, 89, except costs related to interns and residents.

For line 30 (Adults and Pediatrics), include a decreasing adjustment, if applicable, for the swing bed costs reported on the CMS-2552 Worksheet D-1, Part I, line 26, and for the private room differential costs reported on Worksheet D-1, part I, line 36.

Column 3 – Total Costs

Sum of costs from column 1 and column 2. [This column will auto-populate.]

Column 4 – Charges

Enter charges from the hospital's most recently filed Medicare cost report (CMS 2552) Worksheet C, Part I, column 8.

Column 5 – Hospital Cost-to-Charge Ratios

Calculate the cost-to-charge ratio for each cost center by dividing the total costs for each cost center from column 3 by the respective charges from column 4. [This column will auto-populate.]

Column 6 – Total MassHealth Fee-for-Service Inpatient Charges:

Enter from hospital records inpatient charges by cost center related to MassHealth Fee-for-Service (FFS) and MassHealth Primary Care Clinician (PCC) patients.

MassHealth FFS Inpatient Charges include only those charges for the following:

- Charges for MassHealth FFS members and Primary Care Clinician (PCC) members.
- Medically necessary services as defined in 130 CMR 450.204.
- MassHealth covered inpatient hospital services provided to MassHealth patients eligible pursuant to Titles XIX and XXI at the time of service delivery.
- Charges for members of out-of-state Medicaid programs.

FFS Inpatient Charges may not include:

- Charges associated with services provided to MassHealth members where the service is covered by a Medicaid Managed Care Organization (including a Senior Care Organization and PACE).
- Charges associated with claims that have been final denied for payment by MassHealth;
- Charges associate with state programs that are not Title XIX and Title XXI (e.g. the Children’s Medical Security Plan);
- Charges associated with the professional component of hospital-based physician services ;
- Charges associated with dual-eligible patients (these are reported on Schedule C).

Observation bed charges should be recorded on line 92, not on line 30.

Column 7 – MassHealth FFS Inpatient Costs

For Lines 50 through 117, calculate the MassHealth FFS inpatient costs by multiplying for each cost center the MassHealth FFS inpatient charges from column 6 by the respective hospital cost-to-charge ratios from column 5. [These lines will auto-populate.]

For lines 30-46, costs are determined using a per diem methodology; these cells will automatically be populated after Schedule B has been completed.

Column 8 – MassHealth Fee-for-Service Outpatient Charges

Enter from hospital records outpatient charges by cost center related to MassHealth Fee-for-Service (FFS) and Primary Care Clinician (PCC) patients.

MassHealth FFS Outpatient Charges include only those charges for the following:

- Charges for MassHealth FFS members and Primary Care Clinician (PCC) members.
- Medically necessary services as defined in 130 CMR 450.204.
- MassHealth covered outpatient hospital services provided to MassHealth patients eligible pursuant to Titles XIX and XXI at the time of service delivery.
- Charges for members of out-of-state Medicaid programs.

FFS Outpatient Charges may not include:

- Charges associated with services provided to MassHealth members where the service is covered by a Medicaid Managed Care Organization (including a Senior Care Organization and PACE).
- Charges associated with claims that have been final denied for payment by MassHealth;
- Charges associated with state programs that are not Title XIX or Title XXI programs (e.g., the Children’s Medical Security Plan);
- Charges associated with the professional component of hospital-based physician services
- Charges associated with dual-eligible patients (these are reported on Schedule C).

Observation bed charges should be recorded on line 92, not on line 30.

Column 9 – MassHealth Fee-for-Service Outpatient Costs

MassHealth FFS outpatient costs are determined by multiplying the MassHealth outpatient charges for each cost center from column 8 by the respective hospital cost-to-charge ratios from column 5. [This column will auto-populate.]

Column 10 – Total MassHealth Fee-for-Service Inpatient and Outpatient Costs

Total MassHealth FFS costs are determined by adding the MassHealth inpatient costs from column 7 and the MassHealth outpatient costs from column 9. [This column will auto-populate.]

Schedule B: Computation of Inpatient Routine Cost Center Per Diems

Note: Hospitals should not add lines, delete lines, add columns, or delete columns.

For the purposes of completing Schedule B, patient days entered in Columns 4, 6, 8 and 10 must include only those days wherein a patient fully met, at the time of service, the criteria for the given category (FFS, MMCO, Uninsured, or Dual-Eligible), as set forth in the Instructions to Schedules A and C.

Column 1 – Total Routine Cost Center Inpatient Costs

Enter total costs for each routine cost center as reported on UCCR Schedule A, Column 3, lines 30-46 and 92. [This column will auto-populate.]

Column 2 – Total Inpatient Days

Enter total patient days for each routine cost center from CMS-2552 Worksheet S-3, Part I, Column 8. Do not include on line 30 observation bed days from Worksheet S-3 Part I line 28.

Column 3 – Per Diem

Calculate the average cost per day (per diem) by dividing total costs for each cost center in column 1 by the respective total patient days in column 2. [This column will auto-populate.]

Column 4 – MassHealth Fee-for-Service Inpatient Days

Enter total MassHealth FFS inpatient days for each routine cost center on lines 30-46. Do not include observation bed days from Worksheet S-3 Part I line 28 on line 30.

Column 5 – Total MassHealth FFS Inpatient Costs

Calculate total FFS inpatient costs for each routine cost center by multiplying the days in column 4 by the per diem in column 3. [This column will auto-populate.]

Column 6 – MassHealth MCO Inpatient Days

Enter total MassHealth MCO inpatient days for each routine cost center on lines 30-46. Do not include observation bed days from Worksheet S-3 Part I line 28 on line 30.

Column 7 – Total MassHealth MCO Inpatient Costs

Calculate total MMCO inpatient costs for each routine cost center by multiplying the days in column 6 by the per diem in column 3. [This column will auto-populate.]

Column 8 – HSN and Uninsured Inpatient Days

Enter total Health Safety Net and uninsured inpatient days for each routine cost center on lines 30-46. Do not include on line 30 observation bed days from Worksheet S-3 Part I line 28.

Column 9 – Total HSN and Uninsured Inpatient Costs

Calculate total HSN and uninsured inpatient costs for each routine cost center by multiplying the days in column 8 by the per diem in column 3. Do not include on line 30 observation bed days from Worksheet S-3 Part I line 28. [This column will auto-populate.]

Column 10 – Dual-Eligible Inpatient Days

Enter total dual-eligible inpatient days for each routine cost center on lines 30-46. Dual-eligible patients include all patients eligible for MassHealth and another insurer, such as Medicare or commercial insurance. Do not include on line 30 observation bed days from Worksheet S-3 Part I line 28.

Column 11 – Total Dual-Eligible Inpatient Costs

Calculate total uncompensated care inpatient costs for each routine cost center by multiplying the days in column 10 by the per diem in column 3. [This column will auto-populate.]

Schedule C: Computation of Massachusetts Medicaid Care Organizations (MCO) HSN & Uninsured, and Dual-Eligible Uncompensated Care Costs

Note: Hospitals should not add lines, delete lines, add columns, or delete columns.

For the purposes of completing Schedule C:

- Observation bed charges should be recorded in line 92 not in line 30.
- Massachusetts Medicaid Care Organizations Charges include only those charges for the following:
 - Medically necessary services as defined in 130 CMR 450.204.
 - MassHealth covered inpatient and outpatient hospital services provided to MassHealth patients eligible pursuant to Titles XIX and XXI and enrolled in a MassHealth contracting Medicaid Managed Care plans, Accountable Care Organizations, Senior Care Organization (SCO), One Care plans, Primary Care Subcapitation payments or Program of All-inclusive Care for the Elderly (PACE) programs at the time of service delivery.
- Medicaid MCO Charges may not include:
 - Charges associated with services provided to MassHealth members where the service covered under MassHealth Fee-for-Service, including the Primary Care Clinician program.
 - Charges associated with claims that have been final denied for payment by the MCO;
 - Charges associated with state programs that are not Title XIX and Title XXI programs (e.g., the Children’s Medical Security Plan)
 - Charges reported as HSN or uninsured uncompensated care (below)
- HSN and uninsured Inpatient and Outpatient Charges are defined as those charges associated with care provided by hospitals for medically necessary services, including services reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity provided to:
 - Patients with no source of third-party coverage for the service provided;
 - Low-Income Patients (under state regulation 101 CMR 613.04 or its successor regulation) with no health insurance coverage;
 - Low-Income Patients (under state regulation 101 CMR 613.04 or its successor regulation) whose public or private health insurance plan does not cover the full or partial cost of the service (excluding unpaid coinsurance and/or deductible amounts);

or

- Medicaid eligible patients whose medical service is not paid by MassHealth or the Massachusetts Medicaid MCOs, SCO, PACE programs, or OneCare plans.

The following table provides additional instructions regarding which data should be reported for HSN:

HSN Category	Instructions for reporting charges and payments on UCCR
HSN Primary	Include
HSN Secondary – MassHealth primary	Include
HSN Secondary – Private or Medicare	Do not include if the amount paid by the HSN is a deductible or co-insurance amount.
	Include only if the amount paid by the HSN is for a service that was not covered by the primary insurer.
HSN Partial	Do not include if the amount paid by the HSN is a deductible or co-insurance amount.
	Include only if the amount paid by the HSN is for a service that was not covered by the primary insurer. The amount of the HSN deductible paid by the patient should be reported as revenue on schedule F line 7, column 6.
Medical Hardship	Include only if the patient has no health insurance coverage for the service provided.
	Do not include if the HSN payment for Medical Hardship is for a deductible or co-insurance amount.
Emergency Bad Debt	Include

- HSN and uninsured Uncompensated Care Charges, for the purpose of Schedule C of the UCCR, shall exclude charges associated with:
 - Professional component of physician charges;
 - Overhead charges related to physician services.

- Dual-Eligible Charges shall include only allowable charges for inpatient and outpatient services for patients who are eligible for MassHealth and another health insurance program, such as Medicare or commercial insurance. Dual-Eligible charges may not include:
 - Charges associated with claims that have been final denied for payment by MassHealth;
 - Charges reported as HSN and uninsured uncompensated care (below)

Column 1 – Hospital Cost-to-Charge Ratios

Enter the hospital cost-to-charge ratio for each cost center from Schedule A: MassHealth Fee-for-Service (FFS) Costs column 7. [This column will auto-populate.]

Column 2 – Massachusetts Medicaid MCO Inpatient Charges

Enter from hospital records inpatient charges, by cost center, related to Massachusetts Medicaid MCO patients.

Column 3 – Massachusetts Medicaid MCO Inpatient Costs

Massachusetts Medicaid MCO inpatient costs are determined by multiplying the Massachusetts Medicaid MCO inpatient charges for each cost center from column 2 by the respective hospital cost-to-charge ratios from column 1. However, for lines 30-46, costs are determined using a per diem methodology via Schedule B. [This column will auto-populate.]

Column 4 – Massachusetts Medicaid MCO Outpatient Charges

Enter from hospital records outpatient charges, by cost center, related to Massachusetts Medicaid MCO patients.

Column 5 – Massachusetts Medicaid MCO Outpatient Costs

Massachusetts Medicaid MCO outpatient costs are determined by multiplying the Massachusetts Medicaid MCO outpatient charges for each cost center from column 4 by the respective hospital cost-to-charge ratios from column 1.

Column 6 – Total Massachusetts Medicaid MCO Inpatient and Outpatient Costs

Total Massachusetts Medicaid MCO inpatient and outpatient costs are determined by adding the Massachusetts Medicaid MCO inpatient costs from column 3 and the Massachusetts Medicaid MCO outpatient costs from column 5.

Column 7 – HSN and Uninsured Inpatient Charges

Enter from hospital records inpatient charges, by cost center, related to HSN and uninsured patients.

Column 8 – HSN and uninsured Inpatient Costs

HSN and uninsured inpatient costs are determined by multiplying the HSN and uninsured inpatient charges for each cost center from column 7 by the respective hospital cost-to-charge ratios from column 1. However, for lines 30-46, costs are determined using a per diem methodology via Schedule B. [This column will auto-populate.]

Column 9 – HSN and Uninsured Outpatient Charges

Enter from hospital records outpatient charges, by cost center, related to HSN and Uninsured patients.

Column 10 – HSN and Uninsured Outpatient Costs

HSN and Uninsured outpatient costs are determined by multiplying the HSN and uninsured outpatient charges for each cost center from column 9 by the respective hospital cost-to-charge ratios from column 1.

Column 11 – Total HSN and Uninsured Inpatient and Outpatient Costs

Total HSN and Uninsured inpatient and outpatient costs are determined by adding the HSN and Uninsured inpatient costs from column 8 and the HSN and Uninsured outpatient costs from column 10.

Column 12 – Dual-Eligible Inpatient Charges

Enter from hospital records inpatient charges, by cost center, related to Dual-Eligible patients.

Column 13 – Dual-Eligible Inpatient Costs

For Lines 50 through 117, Dual-Eligible Uncompensated Care inpatient costs are determined by multiplying the Dual-Eligible uncompensated care inpatient charges for each cost center from column 12 by the respective hospital cost-to-charge ratios from column 1; for lines 30-46, costs are determined using a per diem methodology via Schedule B. [This column will auto-populate].

Column 14 – Dual-Eligible Outpatient Charges

Enter from the hospital records outpatient charges by cost center related to dual-eligible patients.

Column 15 – Dual-Eligible Outpatient Costs

Dual-Eligible outpatient costs are determined by multiplying the Dual-Eligible outpatient charges for each cost center from column 14 by the respective hospital cost-to-charge ratios from column 1.

Column 16 – Total Dual-Eligible Inpatient and Outpatient Costs

Total dual-eligible inpatient and outpatient costs are determined by adding the dual-eligible inpatient costs from column 13 and the dual-eligible uncompensated care outpatient costs from column 15.

Schedule D: Computation of Uninsured Uncompensated Care Physician Costs
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Note: Hospitals should not add lines, delete lines, add columns, or delete columns.

Hospitals may only claim physician expenses for the following three categories:

1. Professional component of provider-based physician costs, including contracted physician costs, which are not part of inpatient hospital billing;
2. Provider component of provider-based physician costs reduced by Medicare reasonable compensation equivalency (RCE) limits, subject to applicable Medicare cost principles;
3. Administrative costs of the hospital's billing activities received by the hospital associated with provider-based physician services who are employees of or contracted by the hospital.

Professional component expenses should be reported using the allocation method specified in the UCCR schedule D. For patient services provided by the hospitals, hospitals may claim the professional component for physicians employed by the hospital, from contracted physicians, or physicians employed by "related organizations," as that term is defined at 42 CFR 413.17. If the professional component amounts for contracted physicians or related organization physicians are not included on the hospital's CMS 2552 Worksheet A-8-2 column 4 (as indicated on Schedule D), the hospital may add these amounts to schedule D column 1, provided that the hospital determines the professional component costs in accordance with Medicare reasonable cost principles. Note that the hospital must also report on UCCR Schedule F all professional fee revenue related to the professional component costs claimed by the hospital.

The provider component of provider-based physician costs for employees directly employed or contracted by the hospital should be included in the standard UCCR cost allocation method, therefore no separate claim should be made for these expenses. The provider component may be claimed on Schedule E, provided that the hospital determines the costs in accordance with Medicare reasonable cost principles, including the application of the Reasonable Compensation Equivalent (RCE) limits.

The administrative costs of the hospital's billing activities received by the hospital associated with provider-based physician services who are employees of or contracted by the hospital may be claimed as part of the standard UCCR allocation process if the expenses are included CMS-2552 Worksheet A column 7. Otherwise, the hospital may claim the expenses on Schedule E. The following are not allowable claims for physician expenses:

- Total or Medicaid-specific physician practice losses;
- Direct payments made by the hospital to a related physician group for general financial support;
- Overhead expenses for related physician groups.

For purposes of completing Schedule D:

MassHealth FFS Charges include only those charges for the following:

- Charges for MassHealth FFS members and Primary Care Clinician (PCC) members.
- Medically necessary services as defined in 130 CMR 450.204.
- MassHealth covered hospital-based professional services provided to MassHealth patients eligible pursuant to Titles XIX and XXI at the time of service delivery.
- Charges associated with the professional component of hospital-based physician services.
- Charges for out-of-state Medicaid members.

FFS Charges may not include:

- Charges associated with services provided to MassHealth members where the service is covered by a Medicaid Care Organization (including a Senior Care Organization and PACE).
- Charges associated with claims that have been final denied for payment by MassHealth;
- Charges associated with state programs that are not Title XIX or Title XXI programs (e.g., the Children's Medical Security Plan);
- Charges associated with dual-eligible patients (these are reported on Schedule C).

Massachusetts Medicaid Care Organization Charges include only those charges for the following:

- Medically necessary services as defined in 130 CMR 450.204.
- MassHealth hospital-based professional services provided to MassHealth patients eligible pursuant to Titles XIX and XXI and enrolled in a MassHealth contracting Managed Care plans, Senior Care Organization (SCO), One Care plans, or Program of All-inclusive Care for the Elderly (PACE) programs at the time of service delivery.
- Charges associated with the professional component of hospital-based physician services.

Medicaid MCO Charges may not include:

- Charges associated with services provided to MassHealth members where the service covered under MassHealth Fee-for-Service, including the Primary Care Clinician program.
- Charges associated with claims that have been final denied for payment by the MCO;
- Charges associated with state programs that are not Title XIX and Title XXI programs (e.g., the Children's Medical Security Plan)
- Charges reported as HSN or uninsured uncompensated care (below)

HSN and uninsured hospital-based professional services are defined as those charges associated with care provided by hospitals for medically necessary services, including services reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the member

that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity provided to:

- Patients with no source of third-party coverage for the service provided;
- Low-Income Patients (under state regulation 101 CMR 613.04 or its successor regulation) with no health insurance coverage;
- Low-Income Patients (under state regulation 101 CMR 613.04 or its successor regulation) whose public or private health insurance plan does not cover the full or partial cost of the service (excluding unpaid coinsurance and/or deductible amounts); or
- Medicaid eligible patients whose medical service is not paid by MassHealth or the Massachusetts Medicaid MCOs, SCO, PACE programs, or OneCare plans.

The following table provides additional clarification regarding reporting of HSN data on the UCCR:

HSN Category	Instructions for reporting charges and payments on UCCR
HSN Primary	Include
HSN Secondary – MassHealth primary	Include
HSN Secondary – Private or Medicare	<p>Do not include if the amount paid by the HSN is a deductible or co-insurance amount.</p> <p>Include only if the amount paid by the HSN is for a service that was not covered by the primary insurer.</p>
HSN Partial	<p>Do not include if the amount paid by the HSN is a deductible or co-insurance amount.</p> <p>Include only if the amount paid by the HSN is for a service that was not covered by the primary insurer.</p> <p>The amount of the HSN deductible paid by the patient should be reported as revenue on schedule F line 7 column 6.</p>
Medical Hardship	<p>Include only if the patient has no health insurance coverage for the service provided.</p> <p>Do not include if the HSN payment for Medical Hardship is for a deductible or co-insurance amount.</p>
Emergency Bad Debt	Include

Dual-Eligible Charges shall include only allowable charges for inpatient and outpatient services for patients who are eligible for MassHealth and another health insurance program, such as Medicare or commercial insurance. Dual-Eligible charges may not include:

- Charges associated with claims that have been final denied for payment by MassHealth;
- Charges reported as HSN and uninsured uncompensated care

Column 1 – Professional Component of Physicians’ Costs

The professional component of physicians’ costs come from the hospital’s most recently filed Medicare cost report (CMS 2552) Worksheet A-8-2, column 4.

Column 2 – Overhead Costs Related to Physicians’ Services

If the overhead costs related to physicians’ services were adjusted out of the physicians’ costs entered on Worksheet A-8-2, enter those overhead costs from Worksheet A-8 to the corresponding cost center.

Column 3 – Total Physicians’ Costs

Total Physicians’ costs are determined by adding column 1 and column 2. [This column will auto-populate.]

Column 4 – Total Physician Inpatient and Outpatient Charges

Enter the total charges related to physician inpatient and outpatient services from hospital records to the corresponding cost center.

Column 5 – Cost-to-Charge Ratios

For each cost center, a cost-to-charge ratio is calculated by dividing total physicians’ costs in column 3 by total physician charges in column 4. [This column will auto-populate.]

Column 6 – MassHealth FFS Physician Inpatient and Outpatient Charges

Enter by cost center the total charges related to physician inpatient and outpatient services for MassHealth FFS patients from hospital records.

Column 7 – MassHealth FFS Physician Inpatient and Outpatient Costs

MassHealth FFS physician inpatient and outpatient costs are determined for each cost center by multiplying the MassHealth FFS inpatient and outpatient physician charges from column 6 by the cost-to-charge ratio from column 5. [This column will auto-populate.]

Column 8 – Massachusetts Medicaid MCO Physician Inpatient and Outpatient Charges

Enter the total charges related to physician inpatient and outpatient services for Massachusetts Medicaid MCO patients from hospital records.

Column 9 – Massachusetts Medicaid MCO Physician Inpatient and Outpatient Costs

Massachusetts Medicaid MCO physician inpatient and outpatient costs are determined for each cost center by multiplying the Massachusetts Medicaid MCO inpatient and outpatient physician charges from column 8 by the cost-to-charge ratio from column 5. [This column will auto-populate.]

Column 10 – HSN and uninsured Physician Inpatient and Outpatient Charges

Enter the total charges related to physician inpatient and outpatient services for HSN and uninsured patients from hospital records.

Column 11 – HSN and uninsured Physician Inpatient and Outpatient Costs

HSN and uninsured physician inpatient and outpatient costs are determined for each cost center by multiplying the HSN and uninsured inpatient and outpatient physician charges from column 10 by the cost-to-charge ratio from column 5. [This column will auto-populate.]

Column 12 – Dual Eligible Uncompensated Care Physician Inpatient and Outpatient Charges

From provider records, enter the charges related to physician inpatient and outpatient services for Dual Eligible patients as defined above.

Column 13 – Dual Eligible Physician Inpatient and Outpatient Costs

Dual Eligible physician inpatient and outpatient costs are determined for each cost center by multiplying the Dual Eligible inpatient and outpatient physician charges from column 12 by the cost-to-charge ratio from column 5. [This column will auto-populate.]

Column 14 – Total UCCR Physician Costs

Total UCCR physician costs are determined by adding column 7, column 9, column 11, and column 13.

Schedule E: Safety Net Health Care System Expenditures

Pursuant to Section 49(c) of the 1115 demonstration Special Terms and Conditions, expenditures for payments to provider is authorized under the safety net care pool to support uncompensated care for “Medicaid FFS, Medicaid managed care, and low-income uninsured individuals.” This Schedule E provides health care providers the opportunity to itemize such system expenditures for the Medicaid-eligible and uninsured population and includes additional allowable costs outlined in the Cost Protocol approved by CMS and any additional allowable costs described in the Cost Limit Protocol.

Hospitals may use Schedule E to report two types of expenses:

1. Expenses that are not on the hospital’s CMS-2552, therefore not captured in the prior schedules, or
2. Expenses that are disproportionately incurred for Medicaid, HSN, and uninsured populations.

Hospitals should generally report physician expenses on Schedule D, instead of Schedule E. Please refer to the instructions for Schedule D regarding the allowable claims for physician expenses and the circumstances under which hospitals may use Schedule E to report physician expenses. Please note, that the following are not allowable claims for physician expenses:

- Total or Medicaid-specific physician practice losses;
- Direct payments made by the hospital to a related physician group for general financial support;
- Overhead expenses for related physician groups
- Hospital assessment costs, including reallocation of hospital assessments to public payers only. Note that hospital assessments will allocated based on Medicare cost reporting principles.
- Costs that exceed Reasonable Compensation Equivalents (RCE) under Medicare cost principles

The structure of Schedule E will automatically calculate the allowable amount to be claimed on Schedule E for both of these situations.

Column 1 – Hospital Description

Enter a description of the expenses being claimed. If it is a distinct program name, provide the name of the program.

Column 2 – Total SNHCS Expense

Enter total safety net health care system expenditures for each line item. This amount should reflect the total expense for the item, for all patients.

Column 3 – Schedule E Allowable Category

Select the type of expense from the list of allowable categories. The list includes all categories of expenses that are allowed to be claimed on the UCCR in accordance with the Cost Limit Protocol. The list is also provided in Table E-1 below.

If the expense cannot be classified into one of these allowable categories, it is not an allowable expense and should not be reported on the UCCR.

Column 4 – Included on 2552

If the expense is included on the hospital's CMS-2552, specifically as part of worksheet A column 7, then select "yes" from the drop-down list.

If the expense is not included on the hospital's CMS-2552, specifically as part of worksheet A column 7, then select "no" from the drop-down list. Note that this may include some expenses that were reported as part of the hospital's trial balance (worksheet A column 5), but adjusted out in worksheet A column 6.

Column 5 – Payer Mix Proportion

Enter the proportion of the expense that is allocable to Medicaid-eligible, HSN, and uninsured patients. The payer mix proportion should reflect the relative share of expense that is attributable to the Medicaid-eligible and uninsured populations. Hospitals may use any reasonable allocation method to determine this proportion, including but not limited to proportion of costs, charges, or units of service.

Column 6 – Schedule E Allocation Ratio

This column will automatically calculate. If the hospital responded "yes" in column 4, the allocation ratio will be the difference between the amount in column 5 and the ratio of the Medicaid-eligible, HSN, and uninsured expenses to total expenses, as determined through the UCCR allocation method. If the hospital reported "no" in column 4, the amount the hospital reported in column 5 will be used in column 6.

Column 7 – Allowable Schedule E Expense

This column will automatically calculate. The amount is the product of the total system expense reported in column 2 and the Allocation ratio determined in column 6.

Table E-1: Cost Limit Protocol Allowable Expenses:

Cost Element	Inpatient Services	Outpatient Hospital Services	Chronic Disease and Rehab – Inpatient	Chronic Disease and Rehab – Outpatient	Psychiatric Inpatient Hospital	Psychiatric Outpatient Hospital	Substance Abuse Treatment – Inpatient	Substance Abuse Treatment – Outpatient
Professional component of provider-based physician costs, including contracted physician costs, which are not part of the inpatient hospital billing	X	X	X	X	X	X		
Provider component of provider-based physician costs reduced by Medicare reasonable compensation equivalency (RCE) limits, subject to applicable Medicare cost principles	X	X	X	X	X	X		
Administrative costs of the hospital's billing activities associated with physician services who are employees of the hospital billed and received by the hospital	X	X	X	X	X	X		
Patient and community education programs,	X	X	X	X	X	X	X	X

Cost Element	Inpatient Services	Outpatient Hospital Services	Chronic Disease and Rehab – Inpatient	Chronic Disease and Rehab – Outpatient	Psychiatric Inpatient Hospital	Psychiatric Outpatient Hospital	Substance Abuse Treatment – Inpatient	Substance Abuse Treatment – Outpatient
excluding cost of marketing activities								
Telemedicine services	X	X	X	X	X	X	X	X
Addiction Services	X	X	X	X	X	X		X
Community Psychiatric Support and Treatment		X		X		X		X
Medication Administration		X				X		
Vision Care		X						
Health care for the house bound and the homeless, family planning, and pre-natal, labor, and post-natal support for at risk pregnancies. CMS 255-10, Line 193		X						
Social, Financial, Interpreter, Coordinated Care and other services for Medicaid-eligible and uninsured patients	X	X	X	X	X	X	X	X

Cost Element	Inpatient Services	Outpatient Hospital Services	Chronic Disease and Rehab – Inpatient	Chronic Disease and Rehab – Outpatient	Psychiatric Inpatient Hospital	Psychiatric Outpatient Hospital	Substance Abuse Treatment – Inpatient	Substance Abuse Treatment – Outpatient
340b and other pharmacy costs		X						
Graduate Medical Education	X	X	X	X	X	X		
Outlier Day: Each day beyond 20 acute days, during a single admission, for which a member remains hospitalized at acute status	X							
Psychiatric Day Treatment Program Services		X				X		
Dental Services		X						
Intensive Early Intervention Services for Children with Autism Spectrum Disorder	X	X						
Diversionsary Behavioral Health Services	X	X	X	X	X	X	X	X
Public Hospital Pensions and Retiree Benefits	X	X						

Schedule F: Medicaid and Uninsured Revenue

On this schedule, hospitals should report the revenue received for services provided to Medicaid, HSN, or uninsured patients.

Line Instructions:

Hospital and Clinic Revenue:

In lines 1-8, enter amounts paid for services provided by the hospital and any clinics, including federally qualified health centers, owned by the hospital.

Line 1 – Payer Medical Claims Revenue

For each column, enter in line 1 the total amount paid by the payer for medical claims. Do not include payments for that are not related to claims, such as pay-for-performance payments or supplemental payments. The amounts reported must reflect any post-payment reconciliations or recoupments, subject to the availability of that data.

Column 5 - Health Safety Net

In line 1, column 5, report the gross payments received from the Health Safety Net. Do not offset the amount of the Hospital Assessment.

Hospitals should report the annual amount received from the HSN minus any shortfall. This amount is indicated on the monthly HSN invoice as “monthly gross liability from HSN.” If a hospital did not receive an HSN payment because their shortfall allocation exceeded its gross claims, the hospital should report \$0 for HSN payments.

Column 6 – Dual-eligible

In line 1, column 6, report the payments received from Medicaid (MassHealth or the Medicaid MCO) for patients who are eligible for Medicaid and Medicare or other third party payer.

Line 2 – Payer Performance or Incentive Payment Revenue

Enter in line 2 any amounts received from the payer for performance or other incentive payments, including but not limited to:

- Pay-for-Performance payments;

- Disability access incentive payments;
- The portion of a Safety Net Provider Payment that is a performance-based incentive (the non-performance based portion should be reported as Supplemental Payments)
- Quality incentive payments;
- Delivery System Transformation Initiative Payments;
- Patient Centered Medical Home payments, including care management and care coordination payments;
- Shared Savings and other risk-based payments under and alternative care payment arrangement;
- Electronic Health Record (EHR) payments;
- Infrastructure and Capacity Building Grants or any other grants or awards;
- Clinical Quality Incentive Payments
- Hospital Quality and Equity Initiative Payments
- Other grants or awards from the CMS innovation center or other federal programs.

Column 1 - Medicaid FFS Inpatient

In line 2, column 1, report the payments received from Medicaid (MassHealth or the Medicaid MCO) related to hospital's accessible medical and diagnostic equipment for individuals with disabilities (disability access incentive payments)

All amounts reported in line 2 must also include any recoveries made by the payer for performance issue, such as retrospective performance penalties.

Line 3-5 – Supplemental Payments

Enter in lines 3-5 any amounts received from the payer for supplemental payments, including but not limited to:

- High Public Payer Hospital Supplemental Payment
- High Public Payer Behavioral Health Service Supplemental Payment
- High Medicaid Volume Safety Net Hospital Supplemental Payment
- High Medicaid Volume Safety Net Hospital HLHC Supplemental Payment
- Essential MassHealth Hospitals Payment
- Safety Net Provider Payment
- Medicaid Rate Add-On
- Targeted Medicaid Payments
- Specialized Pediatric Service Hospital Supplemental Payment
- Promote Hospital Capacity to Provide Enhanced ED Psych. Services Payment
- Pediatric and Infant Outlier
- Primary Care Subcapitation payments
- Infant and pediatric outlier payments

Specify the type of supplemental payment reported by modifying the title of the line. The total gross payment must be reported; do not offset any payment amount by any intergovernmental transfer amounts that may have been made by a related public entity.

Line 6 – Medicare Revenue

Enter in line 6 any payments amounts received from Medicare for services provided to dually-eligible patients. Note that Medicare revenue should not be reported for columns 1 through 4, as these columns are only applicable for patients that have only Medicaid or Medicaid MCO coverage.

Line 7 – Third Party and Self Pay Revenue

Enter in line 7 any payment amounts received from third parties, the patient, or the patient's guarantor for the cost-sharing or services not covered by the payer noted in the column. For columns 1-4, the amount reported should include only self-payments related to cost-sharing or other patient payments received from MassHealth. Patients who are covered by a third party payer and Medicaid are dually-eligible and revenue should be reported in column 6.

Line 8 – Other Revenue

Enter in line 8 any additional revenue received from the payer not included in lines 1-7. Specify the type of revenue by modifying the title of the line. Additional information may be provided in the Notes tab.

Line 9 – Subtotal Hospital and Clinic

Sum of lines 1-8. [This line will auto-populate]

Lines 10-15 Physician Revenue:

Using the same descriptions in the corresponding lines 1-8, report physician revenue related to the payers.

Line 16 – Subtotal Physician Revenue

Sum of lines 10-15. [This line will auto-populate].

Line 17 – Total Revenue.

Sum of lines 9 and 16. [This line will auto-populate].

Line 18 – Total Cost Limit Protocol Revenue

Line 18 subtracts lines 2 and 11 from line 17. [This line will auto-populate]. For the purposes of the Cost Limit Protocol, performance-based, incentive, grant, and shared savings payments are not counted as revenue.

Column Instructions.

Column 1 – Medicaid FFS Inpatient Revenue

Report in column 1, amounts received from MassHealth for inpatient services provided to members enrolled in the MassHealth program, excluding those enrolled in MassHealth Managed Care Programs.

Column 2 – Medicaid FFS Outpatient Revenue

Report in column 2, amounts received from MassHealth for outpatient services provided to members enrolled in the MassHealth program, excluding those enrolled in MassHealth Managed Care Programs.

Column 3 – Medicaid Managed Care Inpatient Revenue

Report in column 3, amounts received from Medicaid Managed Care Organizations for inpatient services provided to members.

Column 4 - Medicaid Managed Care Outpatient Revenue

Report in column 4, amounts received from Medicaid Managed Care Organizations for outpatient services provided to members.

Column 5 – HSN and Uninsured Inpatient & Outpatient Revenue

Report in column 5, amounts received from the Health Safety Net and uninsured individuals for inpatient and outpatient services provided. Report the gross payments received from the Health Safety Net. Do not offset the amount of the Hospital Assessment.

Column 6 – Dual-Eligible Inpatient & Outpatient Revenue

Report in column 6, amounts received from all payers for patients eligible for Medicaid and another insurer. Line 1 should include payments from Medicaid or the Medicaid MCO.

Column 7 – Total Revenue

Sum of columns 1 through 6. [This column will auto-populate.]

Schedule G: Notes

Use the space provided on Schedule G to provide any additional notes or clarifications regarding the data provided on the UCCR.

Schedule H: Status of Prior Year Filings

Please report the current filing status of the hospital's CMS-2552 and UCCR filings.

Schedule I: Validation

Schedule I includes data validation checks on the prepared data.

Section A compares the reported values with the same elements extracted from the CMS-2552 public use file. The checks include the following:

- Costs, including interns and residents
- Total charges
- Total patient days.

Section B includes internal completeness and consistency checks on the prepared data. These checks include:

- Dual Eligible expenses or revenue reported, but associated revenues or expenses are omitted.
- Physician expenses or revenue reported, but associated revenues or expenses are omitted.
- Dual Eligible physician expenses or revenue reported, but associated revenues or expenses are omitted.
- Did not answer whether Hospital Assessment was reported as an expense on CMS 2552
- Did not provide Hospital Assessment amount
- Observation reclass total is not zero.

The source of the compared elements is noted on the schedule. If the "Explanation Requested" value indicates "Yes" the hospital must either correct the data or provide an explanation for the variance in the "Hospital Response" column.

Hospitals should not alter this schedule in any way.

Schedule I: Limit Calculation

Schedule I will automatically populate. This schedule completes the cost limit calculation for the hospital based on the information provided on the previous schedules. Note that the data presented on Schedule I is preliminary and may change after EOHHS has completed its review of the UCCR.

Hospitals should not alter this schedule in any way.