Waiver Cost Protocol
Uncompensated Care Cost Report (UCCR)
Training Webinar

Executive Office of Health and Human Services

June 14, 2023

Agenda

1. Introductions and Webinar Process

2. Review of Waiver Cost Limit Protocol

3. Uncompensated Care Cost & Charge Report
   - Overview
   - Review of Schedules
   - Submission Process

4. Questions and Answers

Introductions and Webinar Process

1. Introductions

2. Webinar Process
   - Webinar is being recorded
   - Submit questions in the “Q&A” section at the bottom
   - Will be emailing the template and instructions after this webinar
   - Filing information, this slide deck, template and instructions will be posted on EOHHS web page

Waiver Cost Limit Protocol: Overview

The protocol is a requirement of the Commonwealth's 1115 Medicaid Waiver

- Special Term and Condition (STC) 11.5
- Full protocol details are in Attachment to Waiver

- Requires that Safety Net Care Pool provider payments be limited on a provider-specific basis to the uncompensated care of providing services to Medicaid-eligible and uninsured individuals

- Effective with federal fiscal year 2015

Payments Subject to the Cost Limit

- Payments that are made to hospitals under the “DSH-Like Pool” in the approved 1115 Waiver are subject to the protocol
- Only the **provider payments** included in SNCP are specifically limited by the protocol.

Provider Payments (Limited by Protocol)
• 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

- Incentive payments are not subject to the cost limit.

Cost Limit Protocol Calculation

The limit is determined on a hospital-specific basis:

Limit = (Medicaid Costs + Uninsured Costs)
– (Payments received for Medicaid, Uninsured and Health Safety Net patients)

- Hospitals must file and EOHHS is required to use the Uncompensated Care Cost and Charge Report (UCCR) for this calculation
  - Based on the CMS-2552
  - Collects cost center charges for Medicaid and uninsured services, converts to costs using the 2552 methods, and also collects payment information

Interim and Final Calculations

Interim calculation

- Based on as-filed 2552 report

Final calculation

- Based on CMS settled/audited or 2552 cost report

Uncompensated Care Cost and Charge Report (UCCR)

Which Hospitals Must File

Hospitals that are eligible to receive payments from the Safety Net Care Pool must file a UCCR.

The UCCR uses CMS-2552 cost apportionment methods

- Same cost centers as CMS-2552
- Routine costs: Product of per diem cost and payer days
- Ancillary costs: Product of cost-to-charge ratio and payer charges

UCCR Overview

Schedules	Purpose
Cover Sheet	Hospital and report information
A	Collect FFS charge data, calculate FFS costs
B	Calculates Routine Per Diems used in calculations
C	Calculates Medicaid MCO, HSN, Uninsured, Duals costs
D	Calculates Physician costs (FFS, MCO, HSN, Uninsured, Duals)
E	Collects Additional allowable expenses
F	Collects Revenue Data
G	Space for hospitals to provide notes
H	Tracking for prior year filings
I	Validation Tab (New)
J	Cost Limit Calculation

Cover Page

- Hospital name, UCCR version, and the hospital assessment questions are drop-down functions.

- Data carries over to subsequent sheets

Schedule A: MassHealth FFS Costs

Schedule A calculates the cost-center specific cost-to-charge ratios Hospitals will provide data from their CMS-2552 for the applicable fiscal year:

- Column 1 - Costs (2552 Worksheet B Part I)
- Column 2 – Observation reclass and certain post-stepdown expenses from supplemental worksheet B-2
- Column 4 - Charges (2552 Worksheet C Part I)

Schedule A: MassHealth FFS Costs

Hospitals will provide MassHealth FFS charges from their records for inpatient and outpatient services

Include on Schedule A charges for inpatient and outpatient services provided to patients enrolled in:

- Primary Care Clinician (PCC)
- Fee-for-Service

** Anything submitted directly to MassHealth should be reported on Schedule A

Do **not** include on Schedule A

- Medicaid managed care or Accountable Care charges
- Primary Care Sub-Capitation
- Physician charges
- Charges for dual-eligibles

Schedule B: Routine Cost Center Per Diems

The UCCR follows the 2552 cost allocation method

- Ancillary Costs: CCR * Charges
- Routine Costs: Per Diem * Days

Hospitals should report patient days on Schedule B for:

- Total Days (2552 Wksht S-3 Part I)
- Medicaid FFS, Medicaid MCO, HSN & Uninsured, and Dual-Eligible (Hospital records)

Schedule B: Routine Cost Center Per Diems

- Costs will be carried forward from Schedule A
- Schedule B will calculate the routine costs and carry those expenses to Schedules A & C for the routine cost centers

Schedule C: Medicaid MCO, HSN & Uninsured, Dual-Eligible Costs

Hospitals should report charges by cost center for these programs on Schedule C

- Medicaid Care Organizations (MCO) (columns 2 & 4: inpatient and outpatient)
- HSN & Uninsured (columns 7 & 9)
- Dual-Eligible (columns 12 & 14)

Schedule C: Medicaid Managed Care, HSN & Uninsured, Dual-Eligible Costs

- Do **not** include physician charges

- Managed Care includes
  - Includes Managed Care Plans
  - Accountable Care Organizations
  - Senior Care Organization and OneCare
  - Mass. Behavioral Health Partnership (MBHP)
  - Primary Care Sub-Capitation

HSN & Uninsured includes
  - HSN eligible (low-income) patients
  - Patients who were uninsured for the service
  - Does not include patients who were covered but did not pay their deductible, co-insurance

Schedule C: Medicaid MCO, HSN & Uninsured, Dual-Eligible Costs

Dual-eligible includes patients who have primary coverage for another program (e.g. Medicare, commercial, etc) and also have MassHealth

Report the value of the charges for the entire stay

- e.g. If Medicare covered the first 10 days of a 30 day stay because the patient exhausted benefits—report the charges for the full 30 days

Schedule D: Uncompensated Physician Costs

- Allowable physician costs
  - Professional component of provider-based physician costs, including contracted physicians, which are not part of inpatient hospital billing
  - Reduced by Reasonable Compensation Equivalents (RCEs)
  - Administrative costs of the hospital's billing activities associated with physician services who are employees of the hospital

Columns 1-5 create a physician cost-to-charge ratio from the 2552

- Col 1: Professional Component (2552 Wksht A-8-2, col 4)
- Col 2: Overhead costs if not already in Col 1 (Wksht A-8)
- Col 4: Total physician IP & OP charges

Schedule E: Safety Net Health Care System Expenditures

Schedule E enables hospitals to report additional allowable expenses for the Medicaid-eligible and uninsured that are:

- Not otherwise captured through the prior schedules (2552 allocation) or that need to be allocated differently, and
- Are an allowable expense per the Waiver Cost Protocol (refer to the table in the instructions, pp. 17-19)

- EOHHS will review the expenses reported on Schedule E and determine if costs are allowable

Schedule E: Safety Net Health Care System Expenditures

Select examples:

- Social, financial, interpreter expenses
- Public health education programs (not marketing)
- Health care for the homeless
- Public hospital pensions

Refer to the instructions on the allowable Schedule E expenses

Schedule E: Safety Net Health Care System Expenditures

The following expenses are **not** allowable Schedule E expenses

- Losses associated with affiliated medical practices or providers
- ACO administrative expenses
- Reallocation of the hospital assessments to shift the expense to public programs
- Reasonable Compensation Equivalent (RCE) disallowances

Refer to the instructions on the allowable Schedule E expenses

Schedule E: Safety Net Health Care System Expenditures

Report the hospital description total expenses

Select the allowable category
Indicate whether the value is reported on Worksheet A on the 2552

Medicaid & HSN/Uninsured payer proportion

- Generally the ratio of Medicaid, HSN, and Uninsured charges (GPSR) as proportion of total charges
- May report different ratio if the costs are disproportionately , but hospital must justify difference in narrative description

Schedule F: Medicaid and Uninsured Revenue

Hospitals should report revenue received corresponding to the charges reported on schedules A-E

Report revenue received from all sources, not only Medicaid and HSN

- i.e. dual-eligible patients will have Medicare or third-party revenue

Performance payments

- Lines 2 & 11 request performance payments (e.g. P4P). These will not be offset against costs for the purpose of the protocol (line 18). Requested to ensure that these amounts are not included elsewhere.

G - Notes Tab

- Use the final tab to report any additional notes regarding the cost report
- May also submit separate attachment in the email submission

H - Report Tracker Tab

For each fiscal year, report the CMS-2552 status

- As submitted
- Settled with or without audit
- Reopened
- Amended

Report whether the hospital has submitted the interim and final reports

I - Data Validation Tab

- New tab to identify (1) variances from the CMS-2552 and (2) internal inconsistencies

- Hospitals must resolve or explain variances prior to filing

J - Limit Calculation

- The Limit Calculation provides the detail of the required calculation

Submission Process

UCCR Filing Schedule per Protocol

UCCRs are to be filed based on the hospital's own fiscal year end

- Filed 3 months after CMS-2552 cost report is filed (i.e. 8 months after FYE)

- To complete the calculation for hospitals with FYEs other than 9/30, EOHHS must prorate cost reports from contiguous time periods

- Interim calculations to be completed within 12 months of UCCR filing

- Final calculations to be completed within 12 months of when audited CMS-2552s are available online

Updated UCCR Filing Schedule
FY22 Calculation Cycle

Hospital FYE	FY22 Standard UCCR Due Date	Revised Due Date
6/30	2/28/2023	7/14/2023
8/31	4/30/2023	7/14/2023
9/30	5/31/2023	7/14/2023
12/31	8/31/2023	8/31/2023

EOHHS will work with individual hospitals re: extension requests

Final Report Submissions

- EOHHS will be contacting hospitals for which we do not have final filings to complete the collection

- Hospitals are required to submit a final UCCR *even if there was no change to the interim filing*

Hospital FYE	FY22 Finals Due By
FY2015	8/31/2023
FY2016	8/31/2023
FY2017	9/30/2023
FY2018	9/30/2023

Final Report Submissions

- Hospitals should be submitting Final UCCR once they have been notified by CMS that the CMS-2552 for a particular year has been settled

  - e.g if a hospital has a settled FY20 CMS-2552 report, it should file the UCCR Final Report with EOHHS

Submission Process

Email the completed UCCR report to:
CostLimitProtocol@state.ma.us

You may also use this email for questions regarding the report or other technical issues

Updated templates and instructions will be available here:
http://www.mass.gov/eohhs/provider/insurance/masshealth/cost-limit-protocol.html

Questions & Answers