



***SPECIFIC INSTRUCTIONS
for completion of the***

DSH and Non-DSH Texas Hospital UC Tools

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TEXAS HEALTH AND HUMAN SERVICES COMMISSION

Table of Contents

Texas Hospital Uncompensated Care Tool (TXHUC) 3

 Certification..... 3

 Summary Schedule..... 3

 Schedule 1 4

 Schedule 2 9

 Schedule 3 12

20XX DSH APPLICATION..... 13

 Cost Report Collection Form 13

 Interim Reconciliation of Physician and Mid-Level Professional Services Payments
 to Hospitals..... 13

 Final Reconciliation of Physician and Mid-Level Professional Services Payments to
 Hospitals 14

Texas Hospital Uncompensated Care Tool (TXHUC)

The TXHUC is comprised of a certification page, 4 primary schedules (a Summary Schedule and Schedules 1, 2 and 3) and two supporting schedules (2011 DSH and Cost Report Collection Form). Schedules 1, 2 and 3 determine the hospital's unreimbursed costs for services provided to Medicaid and Uninsured patients related to physician and mid-level professional direct patient care costs, pharmacy costs, and DSH hospital costs, respectively. The two supporting schedules are the schedules hospitals are required to submit to HHSC when applying for the Medicaid DSH program. Each of these schedules along with instructions for the completion of the schedule is detailed below.

Certification

The certification page must be signed and dated by an officer or administrator of the provider. An officer is defined as a member of the provider's senior management such as the chief executive officer, chief financial officer, chief operating officer, etc. The certification must contain an original signature and not a copy or electronic signature. If the TXHUC is an initial submission, it should be so indicated in the appropriate box on the certification page.

Upon receipt of a final and/or amended final Medicare cost report, the provider is required to submit a "final" TXHUC based on the costs and other data contained in the final cost report. This final TXHUC will be utilized by HHSC to perform a final reconciliation of the actual costs for the period and the cost utilized to determine the provider's distribution from the UC Pool for that period. If the TXHUC submission is a final submission, it should be so indicated in the appropriate box on the certification page.

Upon the termination of the 1115 Waiver, providers will be required to submit actual cost data in the prescribed format of the TCHUC for a minimum of two years for purposes of reconciling the UC Pool payments for the last two years of the Waiver with the provider's actual costs incurred for those fiscal periods

Summary Schedule

Column 1 - Summarizes the Medicaid and Uninsured costs determined on Schedules 1, 2 & 3. These amounts will flow automatically from the respective schedules and no input is required.

Column 2 – The initial distribution of the Uncompensated Care Pool ("UC Pool") for the fiscal period 10/1/2011 – 9/30/2012 will be based on the costs for the period from 10/1/2009

– 9/30/2010 as computed on Schedules 1, 2 & 3. If the provider knows these costs are not representative of their actual costs for the period from 10/1/2011 – 9/30/2012, due to changes in their contractual arrangements or other operational or economic issues, the provider can make an adjustment to these costs. The provider is required to maintain supporting documentation to support their adjustment amount and make this information available upon request from HHSC and/or CMS. The provider may not request any changes that increase its interim hospital specific limit.

Column 3 – Represents the net Medicaid and Uninsured costs after any adjustments and is determined by summing the amounts in Columns 1 & 2. The net cost amount will be utilized to determine the provider’s distribution from the UC Pool.

Schedule 1

The schedule computes the costs related to direct patient care services provided by physicians and mid-level professionals to Medicaid and Uninsured patients. To be included in the schedule, these costs must be recorded on the hospital’s accounting records and reported on the hospital’s Medicare cost report, Worksheet A, Columns 1 and/or 2.

The source for these costs and other data will be the hospital’s Medicare cost report(s) that span the period from October 1 through September 30 two years prior to the demonstration year for which UC payments are being determined. If the hospital’s cost reporting period is other than October 1 through September 30, it will be necessary to pro-rate the costs and other data from the applicable cost reports that span this period.

Column 1 - The direct patient care physician and mid-level professional costs are identified from the Medicare cost report. These professional costs are:

1. Limited to allowable and auditable physician compensations that has been incurred by the hospital;
2. Identified as professional costs on Worksheet A-8-2, Column 4 of the cost report(s);
3. Or, for contracted physicians only, Worksheet A-8, if the physician professional compensation cost is not reported by the hospital on Worksheet A-8-2 because the physicians are contracted solely for direct patient care activities (i.e., no administrative, teaching, research, or any other provider component or non-patient care activities); and
4. Removed from hospital costs on Worksheet A-8 / A-8-2

If the professional physician costs on Worksheet A-8-2, Column 4 include Medicare Part A costs (e.g. departmental administration, hospital committee activities, etc.) that were

reported as professional component due to lack of a physician time study(s) to allocate the costs between professional and provider component and/or application of the Reasonable Compensation Equivalent (RCE) , these costs must be excluded from the physician costs related to direct patient care professional services and cannot be included for UC reimbursement purposes unless the following conditions are met:

- (1) The costs must be allocated between direct patient care (Medicare Part B) and reimbursable Medicare Part A activities. The costs associated with Medicare Part A activities must be subjected to the Medicare RCEs. If the hospital does not have adequate time studies for the application of the RCEs, then the hospital must obtain a proxy, signed and dated by the physician that estimates the amount of time spent on allowable Medicare Part A activities, teaching of interns & residents and medical students, research and direct patient care for the period the costs were incurred. The proxy should account for 100% of the physician's time related to the costs incurred by the hospital. If the costs are for a group of physicians, each physician in the group must complete a proxy.
- (2) For a physician group, the hospital can elect to apply the RCE limit on an individual physician basis or in the aggregate.
- (3) The hospital must allocate the physician costs based on the physician's proxy and apply the applicable RCE limits to the Medicare Part A non-teaching physician costs. The hospital must maintain auditable documentation of the determination of the allowable Part A non-teaching physician costs.
- (4) For cost reporting periods beginning on or after 10-1-2012, the hospital is expected to obtain adequate and auditable time studies from each physician providing Medicare Part A services to the hospital for the proper application of the RCEs via the Medicare 2552 cost report. The physician time study form to be used is attached as Appendix A. Time studies should be completed for a two (2) week period once per quarter during the fiscal year. Ideally, the time study period will not be the same two weeks in any 2 given quarters. Medicare Part A physician costs will not be allowed to be included in the UC tool for cost reporting periods beginning on or after 10-1-2012.

Physician Part A costs in excess of the RCE limits cannot be included in Column 1. Physician costs related to direct patient care and physician Part A costs not in excess of the RCE limits should be reported on the respective line in Column 1 for cost reporting periods ending on or prior to 9-30-2012. For cost reporting period beginning on or after 10-1-2012, Physician Part A costs cannot be included in Column 1. The physicians' costs should be

reported in the cost center in which the expenses were reported on Worksheet A, Column 3 of the Medicare cost report.

Hospital costs for mid-level professional practitioner services that have been identified and removed from hospital costs on the Medicare cost report are to be included. Typically these costs are comprised of salaries and direct fringe benefits (payroll taxes, vacation and sick pay, health and life insurance, etc.), contract fees and professional liability insurance, the mid-level professional practitioner types to be included are:

- (1) Certified Registered Nurse Anesthetists
- (2) Nurse Practitioners
- (3) Physician Assistants
- (4) Dentists
- (5) Certified Nurse Midwives
- (6) Clinical Social Workers
- (7) Clinical Psychologists
- (8) Optometrists

To the extent these mid-level practitioners' professional compensation costs are not included in Worksheet A-8-2, Column 4, but are removed from hospital costs through an A-8 adjustment on the Medicare cost report, these costs may be recognized if the mid-level professional practitioners are Medicaid-qualified practitioners for whom the services are billable under Medicare separate from hospital services.

If the physician and/or mid-level practitioner costs are reported in a non-reimbursable cost center on the hospital's Medicare cost report, Worksheet A, these costs can be included in Column 1. The costs to be included would be the costs from Worksheet B Part I, the last column for the applicable line(s).

Hospitals may include physician support staff compensation, data processing, and patient accounting costs as physician-related costs to the extent that:

1. These costs are removed from hospital inpatient and outpatient costs because they have been specifically identified as costs related to physician professional services;
2. They are directly identified on W/S A-8 as adjustments to hospital costs;
3. They are otherwise allowable and auditable provider costs; and
4. They are further adjusted for any non-patient-care activities such as research based on the physician time studies.

If these costs are removed as A-8 adjustments to the hospital's general service cost centers, these costs should be reported on the General Services line (line 1) in Column 1.

If the hospital has costs for physicians and one or more types of mid-level professional for a given cost center, the costs can be combined and the total reported in Column 1 provided the same allocation statistic will be utilized to apportion the costs to Medicaid and Uninsured. If the hospital elects to utilize different allocation statistics to apportion the physician and/or any type of mid-level professional costs for a given cost center the cost center can be subscripted.

Column 1a – The recommended apportionment statistic for physician and mid-level professional costs is total billed professional charges by cost center. If a hospital does not maintain professional charges by payer type separately in its patient accounting system, then the professional costs can be apportioned based on total billed hospital departmental charges. Total billed hospital departmental charges by cost center are identified from the hospital's applicable Medicare cost report(s).

If professional charges related to the physician and/or mid-level professional services whose costs are reported in Column 1 are utilized as the apportionment statistic, the professional charges must be from the same corresponding time period as the costs. The hospital must maintain adequate and auditable documentation to support the statistics reported in Column 1a.

If the hospital reports costs on the General Services line (Line 1) in Column 1, the recommended allocation statistic reported in Column 1a would be the aggregate total departmental charges (professional or hospital department, based on the apportionment statistic for the specific cost centers) for all cost centers.

Column 1b – The allocation basis the hospital elects to utilize to apportion the costs from Column 1 should be identified for each cost center. The approved allocation bases are total departmental professional charges if available. Otherwise departmental hospital charges may be utilized.

Column 2 - A cost to charge ratio (CCR) for each cost center is calculated by dividing the total costs for each cost center reported in Column 1 by the total allocation statistic for each cost center reported in Column 1a. If additional lines are added to Schedule 1, it will be necessary to copy the formula used to compute the CCR for the additional line(s).

Columns 3a & 3b – The applicable allocation statistics related to the physician and mid-level professional services provided to Medicaid Fee-For Service (FFS) patients are reported in Columns 3a and 3b based on the hospital's elected allocation basis reported in Column 1b. The allocation statistics applicable to Medicaid FFS inpatient services are reported in Column 3a and allocation statistics applicable to Medicaid FFS outpatient services are reported in Column 3b. The Medicaid FFS inpatient and outpatient statistics

should be from the hospital's internal records and for the same fiscal period as the costs reported in Column 1 and total allocation statistics reported in Column 1a. If the hospital provided services to out-of-state Medicaid FFS patients, the charges related to those services should be included in Columns 3a and 3b as applicable.

Columns 3c & 3d – The Medicaid FFS inpatient and outpatient physician and mid-level professional costs are computed based on the CCR reported in Column 2 multiplied by the Medicaid FFS inpatient and outpatient allocation statistics reported in Columns 3a and 3b, respectively. If additional lines are added to Schedule 1, it will be necessary to copy the formula used to compute the Medicaid FFS inpatient and outpatient costs for the additional line(s).

Columns 4a & 4b - The applicable allocation statistics related to the physician and mid-level professional services provided to Medicaid Managed Care (HMO) patients are reported in Columns 4a and 4b based on the hospital's elected allocation basis reported in Column 1b. The allocation statistics applicable to Medicaid HMO inpatient services are reported in Column 4a and allocation statistics applicable to Medicaid HMO outpatient services are reported in Column 4b. The Medicaid HMO inpatient and outpatient statistics should be from the hospital's internal records and for the same fiscal period as the costs reported in Column 1 and total allocation statistics reported in Column 1a. If the hospital provided services to out-of-state Medicaid HMO patients, the charges related to those services should be included in Columns 3a and 3b as applicable.

Columns 4c & 4d – The Medicaid HMO inpatient and outpatient physician and mid-level professional costs are computed based on the CCR reported in Column 2 multiplied by the Medicaid HMO inpatient and outpatient allocation statistics reported in Columns 4a and 4b, respectively. If additional lines are added to Schedule 1, it will be necessary to copy the formula used to compute the Medicaid HMO inpatient and outpatient costs for the additional line(s).

Columns 5a & 5b - The applicable allocation statistics related to the physician and mid-level professional services provided to Uninsured patients are reported in Columns 5a and 5b based on the hospital's elected allocation basis reported in Column 1b. The allocation statistics applicable to Uninsured inpatient services are reported in Column 5a and allocation statistics applicable to Uninsured outpatient services are reported in Column 5b. The Uninsured inpatient and outpatient statistics should be from the hospital's internal records and for the same fiscal period as the costs reported in Column 1 and total allocation statistics reported in Column 1a.

Columns 5c & 5d – The Uninsured inpatient and outpatient physician and mid-level professional costs are computed based on the CCR reported in Column 2 multiplied by the Uninsured inpatient and outpatient allocation statistics reported in Columns 5a and

5b, respectively. If additional lines are added to Schedule 1, it will be necessary to copy the formula used to compute the Uninsured inpatient and outpatient costs for the additional line(s).

All revenue received by the hospital related to physician and mid-level professional services provided inpatients and outpatients covered by Medicaid FFS, Medicaid HMO and Uninsured patients should be reported on Line 102 of the respective Columns 3c & 3d, 4c & 4d and 5c & 5d. The revenue will be subtracted from the respective costs to determine the net costs to be included in the hospital's UC Application.

Schedule 2

The schedule computes the pharmacy costs related to prescription drugs provided by hospitals participating in the Texas Vendor Drug program. These pharmacy costs are not related to services provided by the hospital's retail pharmacy or billed to a third party payer under revenue code 253. If the pharmacy costs were included in the hospital's Texas Medicaid DSH application, they should not be included in the TXHUC application.

Column 1 - The total costs for the cost center that contains the drug costs related to the prescription drugs provided under the Texas Vendor Drug program are reported in Column 1, Line 1. These costs are from the hospital Medicare cost report(s) Worksheet B Part I, last column for the applicable cost center. If the hospital cost reporting period spans September 30, the costs from the two Medicare cost reports that span the period from October 1 through September 30 two years prior to the demonstration year for which UC payments are being determined should be pro-rated and added together to determine the pharmacy costs to be reported in Column 1, Line 1.

Column 1a – The total hospital departmental charges for the cost center that contains the drug charges related to the prescription drugs provided under the Texas Vendor Drug program are reported in Column 1a, Line 1. These charges are from the hospital Medicare cost report(s) Worksheet C Part I, Column 8 for the applicable cost center. If the hospital cost reporting period spans September 30, the charges from the two Medicare cost reports that span the period from October 1 through September 30 two years prior to the demonstration year for which UC payments are being determined should be pro-rated and added together to determine the pharmacy charges to be reported in Column 1a, Line 1.

Column 1b – The allocation basis is hospital departmental charges. If the hospital wants to utilize an alternative allocation basis, they must submit a written request to

Texas HHSC that identifies the alternative allocation basis and an explanation as to why the alternative allocation basis results in a more equitable apportionment of the pharmacy costs. HHSC will provide a written response to the hospital's request within 60 days of receiving the request and their decision is final.

Column 2 – The Cost-to-Charge ratio is computed by dividing the costs reported in Column 1 by the allocation statistic reported in Column 2. The CCR is carried out to six (6) decimal places.

Column 3b – The charges related to the prescription drugs provided to Medicaid FFS patients under the Texas Vendor Drug program are reported in Column 3b, Line 1. These charges are obtained from the hospital's internal records. These charges should be for services provided during the period from October 1 through September 30 two years prior to the demonstration year for which UC payments are being determined. The hospital must maintain the supporting documentation and submit it to HHSC upon request.

Column 3d – The costs related to the prescription drugs provided to Medicaid FFS patients under the Texas Vendor Drug program are computed by multiplying the charges reported in Column 3b by the CCR computed in Column 2.

Column 4b - The charges related to the prescription drugs provided to Medicaid HMO patients under the Texas Vendor Drug program are reported in Column 4b, Line 1. These charges are obtained from the hospital's internal records. These charges should be for services provided during the period from October 1 through September 30 two years prior to the demonstration year for which UC payments are being determined. The hospital must maintain the supporting documentation and submit it to HHSC upon request.

Column 4d – The costs related to the prescription drugs provided to Medicaid HMO patients under the Texas Vendor Drug program are computed by multiplying the charges reported in Column 4b by the CCR computed in Column 2.

Column 5b - The charges related to the prescription drugs provided to Uninsured patients under the Texas Vendor Drug program are reported in Column 5b, Line 1. These charges are obtained from the hospital's internal records. These charges should be for services provided during the period from October 1 through September 30 two years prior to the demonstration year for which UC payments are being determined. The hospital must maintain the supporting documentation and submit it to HHSC upon request.

Column 5d – The costs related to the prescription drugs provided to Uninsured patients under the Texas Vendor Drug program are computed by multiplying the charges reported in

Column 5b by the CCR computed in Column 2.

Line 2 - All revenue received by the hospital related to prescription drug services provided to Medicaid FFS, Medicaid HMO and Uninsured patients should be reported on Line 2 of the respective Columns 3d, 4d and 5d. This includes any rebates received from the Texas Vendor Drug program. The revenue will be subtracted from the respective costs to determine the net costs to be included in the hospital's UC Application.

Schedule 3

The schedule determines the hospital's Medicaid DSH costs (Medicaid shortfall and uninsured costs) in excess of the payments received by the hospital from the Texas Medicaid DSH Program. HHSC will complete the schedule based on the hospital's DSH costs (cap) and the DSH Program payments received by the hospital for the applicable fiscal year (10/1/20XX – 9/30/20YY) as described in the steps below.

Line 1 - For hospitals that submitted a DSH Application to HHSC for the applicable year consisting of the 2011 DSH and Cost Report Collection Form worksheets, HHSC will determine the unreimbursed DSH costs to be reported on Line 1 based on the data per their DSH Application. The hospital may not submit revised data.

If the hospital submitted a complete DSH application (2011 DSH and Cost Report Collection Form worksheets) and did not receive a payment from the DSH Pool, HHSC will determine the unreimbursed DSH costs to be reported on Line 1 based on the hospital's DSH Application submission utilizing the same methodology employed by HHSC in the determination of these costs for DSH Pool payment purposes. The hospital may not submit revised data.

If the hospital did not submit the Cost Report Collection Form worksheet as part of its DSH Application, the hospital must submit this worksheet with its TXHUC Tool. HHSC will utilize the data from the hospital's 2011 DSH worksheet along with the data per the Cost Report Collection Form to calculate the hospital's DSH costs (cap) to be reported on Line 1. HHSC will employ the same methodology used to compute the hospital-specific DSH costs (cap) for the determination of the DSH Pool payments to compute the DSH costs (cap) for inclusion in Line 1.

If the hospital did not submit a DSH application to HHSC, they must complete the 2011 DSH and Cost Report Collection Form worksheets in the TXHUC Tool to allow HHSC to compute their hospital-specific DSH costs (cap) for inclusion in Line 1. HHSC will employ the same methodology used to determine a hospital's DSH costs (cap) utilized in the distribution of DSH Pool payments to determine a hospital's DSH costs (cap) to be included in Line 1.

Line 2 – HHSC will determine the Texas Medicaid DSH Program payments received by the hospital for the applicable fiscal year (10/1/2009 – 9/30/2010) and report the payments on Line 2.

Line 3 – The excess hospital DSH costs are computed by subtracting the DSH payments received on Line 2 from the DSH costs on Line 1. The excess costs will be included in the hospital's costs to determine their distribution from the UC Pool. If the hospital's DSH payments on Line 2 exceeds its DSH costs on Line 1, the negative amount is not offset against the hospital's other UC Pool costs as computed in the TXHUC.

20XX DSH APPLICATION

This schedule is one of the two schedules included in the Texas Medicaid DSH application. If the hospital submitted this schedule to HHSC as part of its Medicaid DSH application for the period from October 1 through September 30 two years prior to the demonstration year for which UC payments are being determined, the hospital should not complete this schedule in conjunction with the submission of the TXHUC Tool. HHSC will utilize the data per the hospital's Medicaid DSH application to compute the amounts to be reported on Schedule 3, Line 1.

If the hospital did not submit a DSH Application to HHSC for the period from October 1 through September 30 two years prior to the demonstration year for which UC payments are being determined, the hospital should complete this schedule in accordance with the instructions contained in the Instructions-DSHData Collection schedule. If the hospital elects to not have its excess hospital DSH costs included in its UC Pool application, the hospital is not required to complete the schedule.

Cost Report Collection Form

This schedule is the second of the two schedules included in the Texas Medicaid DSH application. If the hospital submitted this schedule to HHSC as part of its Medicaid DSH application the period from October 1 through September 30 two years prior to the demonstration year for which UC payments are being determined, the hospital should not complete this schedule in conjunction with the submission of the TXHUC Tool. HHSC will utilize the data per the hospital's Medicaid DSH application to compute the amounts to be reported on Schedule 3, Line 1.

If the hospital did not submit a DSH Application to HHSC or did not submit the Cost Report Collection Form schedule as part of its DSH Application to HHSC for the period from October 1, 2009 through September 30, 2010, the hospital should complete this schedule in accordance with the instructions contained in the Instructions-DSHData Collection schedule. If the hospital elects to not have its excess hospital DSH costs included in its UC Pool application, the hospital is not required to complete the schedule.

Interim Reconciliation of Physician and Mid-Level Professional Services Payments to Hospitals

For the physician and mid-level professional, self-pay pharmacy and unreimbursed Medicaid DSH costs UC payments for FY 2012 are determined utilizing the TXHUC, which is based on data for services furnished during the 10/1/2009 – 9/30/2010. The FY 2012 UC payments are reconciled to the costs per the as-filed Medicare cost reports for the fiscal period 10/1/2011 – 9/30/2012 once the cost report(s) have been filed with the State. If, at the end of the interim reconciliation process, it is determined that a provider received an overpayment, the overpayment will be properly credited to the federal government; if a provider was underpaid,

the provider will receive an adjusted payment amount. Similar interim reconciliations will be conducted for each year of the waiver.

Final Reconciliation of Physician and Mid-Level Professional Services Payments to Hospitals

Once the Medicare cost report(s) for the expenditure year has been finalized by the Medicare Fiscal Intermediary (FI) / Medicare Administrative Contractor (MAC), a reconciliation of the finalized costs to all UC payments made for FY 2012 will be carried out, including adjustments for overpayments and underpayments if necessary. The same method as described for the interim reconciliation will be used except that the finalized Medicare UC physician/mid-level professional cost amounts and updated uninsured data will be substituted as appropriate. 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. Similar interim reconciliations will be conducted for each year of the waiver.