

Questions and Responses

Texas Hospital Uncompensated Care Tool

General Questions:

Question: On the certification page do we put in the date as the last filed cost report or the DSH year? The worksheets are using Fiscal Year 2010.

Response: The hospital's cost reporting fiscal period would be the first cost reporting period included in the UC tool. For example, if the hospital's Fiscal Year End (FYE) is 12/31, the hospital's cost report fiscal period would be 1/1/2009 – 12/31/2009. The period from and to would be the UC reporting period which for the 1st year of the waiver would be 10/1/2009 – 9/30/2010.

Question: A Texas Provider Identification (TPI) that is listed for our hospital is no longer active. It was combined with another TPI but it has a UC Tool listed. Do we need to complete the tool for the TPI that is no longer active or should we notify HHSC that it needs to be updated?

Response: Please email HHSC at UCTools@hhsc.state.tx.us with the impacted TPIs and we will perform the necessary research.

Question: We are working with our Regional Health Plan (RHP) on implementation of the waiver. We are trying to do Inter Governmental Transfer (IGT) planning and have a question about the statewide allocation of UC in the event that UC costs exceed the available pool. We understand that a proportional reduction will be calculated on all providers. However, our question is what will happen if IGT is not committed to fund all of the reduced amounts. In effect, can an IGT provider fund itself back up to the entire UC amount if that happens?

Response: This situation is not addressed in the current waiver payments rules. HHSC will be proposing a rule amendment to address the situation but details of that rule amendment are not yet known. For planning purposes, IGT entities should plan to fund the non-federal share of the provider's full UC amount.

Question: Where care is provided in the following scenarios what physician services are allowable and what physician costs are to be included?

- care is rendered somewhere in the facility claiming the cost
- care is rendered in a hospital facility but paid for by a different hospital facility
- care is rendered in a non-hospital facility owned and operated by the hospital
- care is rendered in a facility neither owned nor operated by the hospital

Response: Regardless of where services are rendered if the hospital incurs the physician and/or mid-level professional costs for services rendered to its patients, these costs can be claimed on the hospital's UC tool. If the entity (hospital or physician) who provided the services is filing its own UC tool, the revenue received from the hospital by the providing entity would be offset against their costs to avoid any duplication of costs and eliminate any profit from reported costs.

Question: Where do we submit the completed tool to?

Response: Submission instructions are located on the RAD website at <http://www.hhsc.state.tx.us/rad/hospital-svcs/index.shtml>.

Question: The cost report collection tab will not allow the reporting of decimal places, can this be fixed?

Response: HHSC has made corrections and this information can now be reported to two decimal places on the revised UC tool.

Question: Do I have to participate in UC?

Response: No, you do not have to participate in UC.

Question: Will the 2012 UC Tool be used for 2013 as well or will we complete the tool again for 2013 with the 2011 data?

Response: Hospitals and eligible physician groups will be required to submit a UC tool for demonstration year (DY) 2 (2013) based on their actual data for the period from 10/1/2010 – 9/30/2011.

Question: Is there a cross-walk template for the 2552-10 cost report?

Response: Yes, the TXHUC tool now includes an informational tab cost center cross walk for matching lines on the 2552-96 to the new 2552-10 Medicare report.

Question: Can HHSC clarify what kinds of physician expenses are allowable/disallowable? For example, direct patient care, research, on-call etc.

Response: Compensation-related costs for direct patient care services are the allowable physician and/or mid-level professional costs to be included in the TXHUC tools. For TXHUCs, it would be the physician and/or mid-level professional costs excluded from the Medicare cost report. For TXPUC, a definition of the allowable physician costs can be found on page 17 of the protocol under the instructions for the completion of Worksheet A-1. Physician costs related to research, on-call, teaching related to approved or unapproved programs, medical director or hospital department head are examples of non-allowable costs for purposes of the UC tools.

Question: If services are purchased from another entity (hospital, imaging center, physician clinic, etc) who would bill for these services?

Response: For inpatients, the entity performing the service would bill the hospital and the hospital would bill the applicable payer. If the services purchased from the performing provider were physician/mid-level professional services or included physician/mid-level professional services and the agreement between the hospital and the service entity assigns the physician/mid-level professional billing rights to the hospital, the hospital can include the costs associated with the physician/mid-level professional services in their UC application on Schedule 1 of the TXHUC. For outpatients, the service entity is required to bill both the technical (facility) portion and the physician/mid-level professional (professional) portion of the service to the applicable payer(s) and should not bill the hospital for these services. If the hospital makes a payment to the service entity as a “subsidy” for providing care to its patient, the hospital cannot include this cost in its UC tool.

Question: What is currently allowed for 501a?

Response: A hospital must have a written contract with the 501a for any costs associated with the 501a to be allowable on TXHUC; in such a situation, reportable costs are limited to actual costs. If the 501a is not a related party to the hospital, the hospital can only report what it paid to the 501a. The 501a’s costs, less their revenues, can be reported on the TXPUC tool if the physician practice is a grandfathered practice. If the 501a is a related party to the reporting hospital, all costs of the 501a are allowable on the TXHUC. For non-related party 501a’s, what the hospital pays the 501a is the hospital’s cost; if the payment is for activities other than direct care, the payment for those activities is administrative and subject to RCE limitations. If the payment is just for direct care there is no need for RCE. If a hospital sends its patients to be seen at a physician’s office, these costs are only allowable on the TXPUC. The only exception is if the hospital sends uninsured patients to a physician and the hospital pays that physician for treating the patient (and there is no other source of payment for the patient), the cost to the hospital is allowable on TXHUC.

Question: Once we have completed our IGT funding process for UC, when can we expect to receive payment?

Response: HHSC is currently estimating about 30 days from receipt of IGT to payment date.

Question: How will FMAP rates be determined for UC payments?

Response: UC payments will use the FMAP for the federal fiscal year (FFY) during which the UC was acquired. For example, if payments are distributed for period DY1 in DY2, the FMAP for DY1 will apply. FMAP's will not vary based on provider ownership type.

Question: Is the final uncompensated cost figures on the Cost Summary tab the amount we would IGT under the model or is that the total amount we would get back, including original IGT? For example, if the figure is \$4M, would we IGT \$4M or \$1.6M (\$4M x 42%)?

Response: The uncompensated cost figure is the total amount you would get back. The IGT requirement would be the state share.

Question: I cannot locate the time-study "Appendix A" that is referenced in the UC Tool Overview.

Response: The physician time-study has not been made available via the website. The time-study will be available via the website upon CMS approval. The time-study is not required for completion of the 2012 UC Tool.

Question: It is my understanding that we only need time studies for situations where we are carving out part Medicare Part A versus Medicare Part B time, is that correct?

Response: Yes, that is correct.

Question: Should Medicare/Medicaid crossover payments and GME payments be included on the UC tool and are the payments from the filed cost report? What about settlement?

Response: For non-DSH hospitals, Hospital Specific Limit (HSL) payments related to GME should be included if received from Medicaid. This should be limited to state-owned teaching hospitals. Medicare cross-over claims are included based on total charges and any payment received related to the claims should be offset (Medicare payment, Medicare GME payment and the Medicaid payment). The treatment of Medicare and Third party claims which received a Medicaid payment for deductible should include the payments received from each entity to the total charges that are converted to cost.

Question: We have a facility that opened in April 2010. Can we submit a UC tool for 2012 or do we have to wait for 2013? We would not have a cost report with 7 months that falls within the 10/1/9-9/30/10 period.

Response: The facility's cost report that covers the period from 4/1/2010 to 9/30/2010 would be pro-rated for the seven month period and the related physician/mid-level professional costs and other data for this seven month period would be reported on the hospital's UC application for FY 2012.

Question: We have a facility that will be opening on 9/1/12 and we will not have a cost report. When would we be able to affiliate with an RHP and submit a tool? Can we submit one for 2012?

Response: The facility's cost report that covers the period from 9/1/2012 to 9/30/2012 would be pro-rated for the one month period and the related physician/mid-level professional costs and other data for this one month period would be reported on the hospital's UC application for FY 2012. A provider's participation in UC is not dependent upon participation in an RHP.

Question: Can you differentiate the difference between a public and a private entity?

Response: (1) "State-owned entity" means that the state directly receives the Medicaid-claims payments.^{FN}

(2) "Non-State-owned public entity" means that a governmental entity other than the state directly receives the Medicaid-claims payments.^{FN}

(3) “Private entity” means that a non-governmental entity directly receives the Medicaid-claims payments.^{FN}

^{FN}: If a governmental entity receives some of the Medicaid-claims payments and a non-governmental entity (e.g., a private operator of the hospital) receives some of the Medicaid-claims payments, please indicate this arrangement in the “Ownership Type” column for your entity.

Schedule 1

This 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 2.

Question: Schedule 1 does not allow for any non-standard or sub-scripted lines in column A as the cells are all protected, can these cells be unlocked?

Response: There was an issue with the cells being locked however HHSC has corrected this issue and you should be able to subscript lines (insert) on Schedule 1.

Question: Schedule 1 only allows input for 1 FYE; our cost report period crosses multiple fiscal years do we need additional space for input?

Response: If your cost reporting period straddles 9/30, you will need to prepare a supplemental excel worksheet, for Schedule 1, that pro-rates the data from the two cost reporting periods that span 10/1/2009 – 9/30/2010 and input the data in Schedule 1.

Question: How do we report physician and/or mid level professional components, when the total hospital Medicaid charges, by department, does not allow for them?

Response: The allocation basis for departmental professional charges which would relate to the allowable professional costs are reported in column 1. If departmental professional charges are utilized as the allocation basis, then the Medicaid Fee for Service/Primary Care Case Management (FFS/PCCM), Medicaid HMO and uninsured charges reported in columns 3a&3b, 4a&4b and 5a&5b would also be departmental professional charges. If however the allocation basis is departmental hospital charges in column 1a then the Medicaid FFS, Medicaid HMO and uninsured charges reported in columns 3a&3b, 4a&4b and 5a&5b would also be departmental hospital charges.

Question: Who bills and collects for the services in the following scenarios:

1. The hospital bills and collects for the physician and/or services, separate from hospital services?
2. The physician organization bills and collects for the physician and/or services separate from hospital services?
3. The hospital bills and collects for physician and/or and hospital services under a global arrangement?

Response:

1. If the hospital bills and collects for the physician and/or mid-level professional services, the costs incurred by the hospital would be the allowable costs to be reported on Schedule 1.
2. If the physician organization bills and collects for the physician and/or mid-level professional services, then the hospital would not incur any physician and/or mid-level professional costs and there would be nothing to report on Schedule 1 of the UC tool. If the hospital pays the physician organization for services provided to its uninsured patients, then the hospital can claim the amount paid to the physician organization for the physician and/or mid-level professional compensation-related portion of the costs on the hospital’s UC tool. If the physician organization who provided the services is filing its own UC tool, the revenue received from the hospital by the providing entity would be offset against their costs to avoid any duplication of costs and eliminate any profit from reported costs.

3. If the hospital bills and collects for the physician and/or mid-level professional services, the costs incurred by the hospital would be the allowable costs to be reported on Schedule 1.

Question: Some of my hospitals have CT Scans and MRI charges yet I see no appropriate line on which to enter them, and I cannot add lines as per the file? (What is the appropriate line to enter charges that involve radiology procedures, such as CT Scan and MRI?)

Response: CT Scans can be reported on line 41.01. MRI could be reported on line 41.02 or 41.03 or one on the blank lines.

Question: How does the hospital reimburse when the hospital compensates physicians and mid-levels on set amount of on-site hours, such as two neurologists that cover a department for 12 hours each day 5 days per week?

Response: If the hospital compensates the physician and/or mid-level professional based on a set amount of hours per day, it will be necessary for the hospital to allocate the costs between direct patient care services and availability services. Only the physician and/or mid-level professional costs related to direct patient care services can be claimed on the UC tool.

Question: How does the hospital reimburse physicians and mid-levels based on RVUs activity or fee-for-service compensation methodology?

Response: If the hospital is compensating the physician and/or mid-level professional only for their direct patient care services, then the actual physician and/or mid-level professional costs incurred would be reported on Schedule 1.

Question: How does the hospital compensate physicians and mid-levels for the difference between the total physician costs and the collections made by the physician organization?

Response: Guarantees paid by the hospital to the physician and/or mid-level professional are not allowable costs to be reported on the UC tool.

Question: Is on-call pay for Emergency Room MDs allowable?

Response: Medicare rules must be adhered to; this is an allowable cost subject to Reasonable Compensation Equivalents (RCEs) as long as not already captured by Schedule 3. MDs bill directly for their services meaning the hospital is only paying for availability; hence the RCE requirement. Payments for “availability” are only allowable if the MD is actually required to be on-site.

Question: How does Reasonable Compensation Equivalents (RCE) work if a physician is 100% UC?

Response: RCE is not required for physicians that are 100% UC. Costs should be reported on the cost center, on Schedule 1, that corresponds to the cost center on the Medicare cost report (worksheet A, column 3) where the costs were recorded. If there are no charges, the hospital will have to develop an imputed charge amount to ensure that 100% of the cost is allocated to UC.

Question: Can you please define “related party?”

Response: The Medicare definition of a related party is when one party has ownership of the other party or has significant influence or control over the other party.

Question: If a hospital has a contract with an academic health center (AHC) to provide ambulatory care in the AHC owned clinic, can the hospital claim those costs? Also consider the same scenario but assume that the hospital has an operating lease on the clinics, but the clinic assets remain the property of the AHC.

Response: In the first scenario, assuming the patient is a registered outpatient of the AHC and the AHC is responsible for performing the billing for both the technical and professional services provided to the

patient, then the AHC can claim the physician/mid-level professional compensation-related uncompensated care on its UC tool. The physician costs incurred by the hospital for services provided to AHC patients in the AHC clinic would be excluded from the physician costs reported by the hospital on their UC tool.

In the second scenario where the AHC clinic is operated by the hospital, assuming the patient is a registered outpatient of the hospital and the hospital is responsible for performing the billing for both the technical and professional services provided to the patient, the hospital would be allowed to claim the compensation-related physician/mid-level professional costs for providing services in the AHC clinic on the hospital's UC tool.

Question: How are the costs recorded for services provided and are not included on the hospital cost report in the following scenarios?

- the hospital has a contractual relationship
- the costs are incurred by a related party,
- the costs are incurred by a not related party

Response: If the hospital does not incur any costs related to the physician and/or mid-level professional direct patient care services and the costs would not be allowable to be claimed on the hospital's cost report under the Medicare related party principle, then the costs cannot be reported on the hospital's TXHUC tool.

If the physician group who provided the services is submitting a TXPUC tool, they could include the physician costs on their TXPUC tool (mid-level professional costs are not allowable on the TXPUC). If the costs for physician and mid-level professional direct patient care services that were rendered in the hospital were incurred by a related party, as defined by the Medicare regulations, but not reported on the Medicare cost report, the actual compensation-related physician and mid-level professional costs can be reported on Schedule 1 of the TXHUC. If the costs are incurred by a non-related party, then the hospital cannot include any costs on its TXHUC tool.

Question: How are the costs recorded for services provided and initially recorded and then removed from the hospital cost report?

Response: Physician and/or mid-level professional costs incurred by a hospital and recorded on their general ledger which are excluded from the Medicare cost report via adjustments on worksheet A-8 and/or A-8-2 are reported in column 1 of Schedule 1 on the TXHUC tool. The costs to be reported are the costs that were incurred and excluded. If the physician group who provided the services to the hospital is submitting a TXPUC tool, the revenue offset by the physician group would be the amount paid by the hospital and received by the physician group to avoid any duplication of costs being claimed and eliminate any "profit." Mid-level professional costs are not allowable on the TXPUC.

Question: If not otherwise included in the hospital's Hospital Specific Limit, should hospitals include physician Medicare Part A costs, such as administrative tasks and research, in the Hospital UC Tool for Demonstration Years 1 and 2, subject to the published RCE limits?

Response: If a hospital incurs physician costs for administrative (Part A) activities that were excluded from the cost report, these costs can be included in the hospital's UC tool, subject to the RCE limits, for cost reporting periods beginning prior to 10-1-2012.

Question: Are Swing bed days to be included on Schedule 1?

Response: Swing bed costs are generally reported on the Adults & Peds line (line 25) since swing bed costs are "carved out" of the Adults & Peds costs on the Medicare cost report. If they are reported on a separate line, line 25 should be subscripted; however the open "blank" lines can be utilized and labeled as Swing bed days.

Question: Where do we record PCCM costs?

Response: PCCM costs should be included with Medicaid Fee For Service Charges.

Question: Is PCCM considered Medicaid HMO?

Response: No, PCCM is not part of Medicaid HMO. PCCM costs should be included with Medicaid Fee For Service Charges.

Schedule 2

This 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. Take home drugs are not allowable under Schedule 2 or Schedule 3 and they should not be included in the TXHUC application.

There are currently no questions for Schedule 2.

Schedule 3

(Unreimbursed Hospital DSH Costs): 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 (10/1/2009 – 9/30/2010) as described in the steps below.

Question: DSH did not include organ acquisition for transplants. Can these costs be included in the UC Tool?

Response: Yes supporting claim data must be submitted showing this was an adjudicated claim for a Medicaid eligible service and Medicaid eligible patient during 10/1/2009 – 9/30/2010.

Question: Can you clarify what goes in the Other allowable State and Federal Payments field? Do I include tax money or is that considered part of our County Indigent Health Care Program?

Response: Other allowable can include state tobacco funds and state trauma funds. County Indigent health care funds should not be included.

Question: We are a DSH hospital preparing the Medicaid and Medicaid MCO data from our internal records (per the instructions) for Schedule 1. It was mentioned that the DSH hospitals should use the data from the Cost to Charge Ratio (CCR) schedules submitted for the 2012 DSH year. If that is correct, will the State be sending out updated instructions?

Response: HHSC will post the DSH supplemental pages that may be used if a hospital does not have Physician charges. The cost report periods and pro-ration periods must be used on all sections of the UC tool.

Question: Can DSH hospitals move back to using Medicaid only CCRS for the UC Tool?

Response: If the hospital can provide better projection for UC, that's fine. However, the hospital must certify that the numbers are based on actuals. Hospitals that are over their limit are subject to recoupment. For advanced UC payments, HHSC will not recalculate the HSL calculated for DSH Program Year 2012

Cost Summary

Question: The DSH data did not include organ acquisition for transplants. Can these costs be included in the UC Tool?

Response: Yes, if the hospital has claims data that supports that this cost was from an adjudicated claim for a Medicaid eligible service and Medicaid eligible patient during 10/1/2009 – 9/30/2010. The claims data must be submitted with the UC tool and reported in Column 2 on the Summary Schedule. The hospital must submit Medicare Worksheet D-4 Computation of Organ Acquisition Costs and Charges for Hospitals Which Are Certified Transplant Centers, with their UC tool.

Question: What can be included in Column 2 of the Cost Summary Tab?

Response: Column 2 exists is to allow providers the ability to make adjustments to their UC costs to reflect what they expect their actual costs to be for the demonstration year. Since the data used was for FY 2010 to make payments for FY 2012, HHSC is allowing providers the option to adjust these costs to more closely approximate their actual costs for FY 2012. For example, a hospital provider may have a contract with a group of emergency physicians to provide patient care services in their ER during FY 2010, but the contract expired and they no longer pay physicians to provide patient care services in their ER in FY 2012. The hospital provider could make an adjustment in Column 2 to remove the costs related to the emergency physicians so they are not overpaid on an interim basis. Or they could have new physician contracts for patient care services in FY 2012 that did not exist in FY 2010 and they want to include those costs. Due to the wide range of possibilities we did not feel we could develop a standard template or methodology to compute the adjustments.

TXPUC Specific Questions

Question: Can you confirm that physician costs for all sites of service should be included in the UC tool?

Response: Yes, physician costs for all sites of service should be included in the UC tool. Any revenues received related to these services would be considered a recovery of costs and offset on worksheet A-8.

Question: Where do I report Part A costs in excess of the RCE limit?

Response: Part A costs in excess of the RCE limit are not allowable and may NOT be included on the UC tool.

Question: Do we include in our UC tool, income guarantees for physicians that provide patient services at the hospital?

Response: Payments to physicians and/or mid-level professionals for related to income guarantees cannot be included as physician and/or mid-level professional costs on the UC tool.

Question: Understanding that mid-level professionals are excluded from the revenue and direct cost calculations, the instructions do not specifically indicate that mid-level expenses are also excluded from the indirect cost rate, the assumption is that these are also to be excluded. Is this correct?

Response: Yes, they are also excluded from the indirect cost rate.

Question: Why are Mid-level professional costs included in the hospital tool, and not in the physician tool?

Response: The intention was to include mid-level professional costs in both the hospital and physician UC tools. However, when the waiver application was submitted to CMS, it included language to the effect that physicians who participated in the former Texas Physician UPL program would be eligible to participate in the UC waiver. The language was intended to define the physician groups who participated in the former UPL program as being the entities who could participate under the UC waiver. Unfortunately, CMS interpreted the language to mean that only physician costs would be paid for under the UC waiver. Therefore, mid-level professionals are excluded from the physician UC tool at this time. An amendment to the UC waiver will be submitted in the future to request to include the costs for mid-level professionals in the physician UC tool.

Question: Can a state academic health center, with fiscal year end of August 31 use twelve months October 1 through September 30?

Response: Yes, using the 12 month period from 10/01/2009-09/30/2010 would be acceptable for the initial submission. Subsequent years will need to utilize data from the respective fiscal years to represent the period from October 1 through September 30.

Question: For the purpose of TXPUC are “outpatients” those seen in the clinic or hospital? For instance a colonoscopy is done outpatient at a hospital, then the patient is seen in the physician’s office/clinic, would they be considered an outpatient?

Response: For physicians, if the patient is seen in the physician’s office/clinic, they would be considered an outpatient. Similarly, if the patient is a registered hospital outpatient and is seen by the physician in an outpatient department of the hospital they would be considered an outpatient. Conversely if the patient is a registered hospital inpatient, they would be considered an inpatient, even if they are seen by the physician in a hospital-operated department (e.g. radiology) or hospital outpatient clinic (e.g. endoscopy clinic).

Question: What is the relationship with the provider when the hospital is claiming the costs, where the professional organization providing the service is a ‘related party’ under Medicare principles, i.e. a physician group controlled or owned by the hospital, for which the hospital is financially responsible?

Response: If the physician and/or mid-level professional who provided the direct patient care services is a related party to the hospital, then the actual costs incurred by the related party are the allowable costs on the TXHUC. If the physician is filing its own TXPUC tool, any revenue received from the hospital, for these direct patient services, should be offset to avoid any duplication of costs.

Question: Which physician groups can complete a TXPUC tool?

Response: Only physician groups that participated in the former Physician UPL program can complete a TXPUC tool. Those physician groups are listed below:

Provider Physician Group	Government Affiliation
JPS Physicians Group, Inc.	John Peter Smith dba Tarrant County Hospital District
RadCare of Texas PA	John Peter Smith dba Tarrant County Hospital District
Carlos Torres, M.D.	University Medical Center-Lubbock, dba Lubbock County Hospital District
Scott Dahlbeck, M.D.	University Medical Center-Lubbock, dba Lubbock County Hospital District
University Medical Center - EC Physicians	University Medical Center-Lubbock, dba Lubbock County Hospital District
University Associates, dba Physicians Network Services Clinic	University Medical Center-Lubbock, dba Lubbock County Hospital District
University Medical Center - Radiology	University Medical Center-Lubbock, dba Lubbock County Hospital District
Community Medicine Associates	University Health System (Bexar County Hospital District)
Scott & White Clinic	Texas A&M Health Science Center
Texas A&M Health Science Center	Texas A&M Health Science Center
Dallas County Hospital District, dba Parkland Health and Hospital System	Dallas County Hospital District, dba Parkland Health and Hospital System
Harris County Hospital District	Harris County Hospital District

University of Texas MD Anderson Cancer Center	University of Texas Health System
University of Texas Medical Branch Galveston	University of Texas Health System
University of Texas Health Science Center Houston	University of Texas Health System
University of Texas Health Science Center at San Antonio	University of Texas Health System
University of Texas Southwestern Medical Center	University of Texas Health System
University of Texas Health Center Tyler	University of Texas Health System
University of North Texas Health Science Center	University of North Texas
Texas Tech Health Science Center	Texas Tech University

TXHUC Specific Questions

Question: Can mid-level professionals be included in the TXHUC tool?

Response: Costs for mid-level professionals can be reported on the TXHUC tool.

Question: For the purpose of TXHUC, are “outpatients” those seen in the clinic or hospital outpatients? For instance a colonoscopy is done in a hospital but are outpatients where an office visit is done in a clinic and are also outpatients. How are outpatients classified in this situation?

Response: For hospitals, the definition of an outpatient is the same for purposes of completing the UC tool as it is for Medicare. If the patient is a registered outpatient of the hospital and receives services in the department of the hospital, the charges associated with these services should be reported on Schedule 1 in the appropriate columns. The one exception to this is if the hospital pays another entity to provide services to its uninsured patients, the portion of the payment related to physician and/or mid-level professional services can be included in column 1 on Schedule 1. It is recommended that these costs be reported on a separate line on Schedule 1. In this instance the Medicaid and uninsured allocation statistics reported in columns 3a, 3b, 4a, 4b, 5a and 5b would equal the total statistics reported in column 1a.

Question: Can we include non-allowable indirect costs (bad debt, loss on sale, advertising expenses, etc.) on the indirect cost ratio calculation?

Response: The non-allowable (bad debts, mid-level professionals, etc.) and allowable direct costs are combined to represent the denominator in the ratio calculation. The rationale is that there are indirect costs applicable to the non-allowable direct costs and these costs should not be included in the TXHUC tool.

Question: Are physician on-call costs, such as a surgeon that is off-site, but can come on-site when called, allowed to be reported on the TXHUC tool?

Response: On-call costs for physicians and/or mid-level professionals are not allowable costs to be reported on the TXHUC tool.

Question: How can we appeal the DSH claims and payment data used to create the Hospital Specific Limit?

Response: The Hospital Specific Limit (HSL) and the claims and payment data used to develop the HSL are not appealable for amounts used on the UC tool. HHSC will not amend the claims data used on the UC tool. HHSC utilized the intermediary adjudicated claims data and will not alter information submitted by providers and reviewed through that process. DSH reports only capture allowed amounts reported on the claim record guidelines for the period of 10/1/2009 - 9/30/2010. Providers have 120 days after adjudication to correct any discrepancies shown in a claim’s R&S including erroneous revenue codes that would lead to fee for service claims being omitted and have been given opportunities to review claims

processed by HMOs. Variances between billed and allowed amounts are not acceptable reasons to request adjustments to the provided UC tool HSL data.