TEXAS MEDICAID 1115 WAIVER

Uncompensated Care Application

Overview

- The intent of the Texas Medicaid Waiver Application ("UC Application") is to provide a simplified way to subsidize specifically identified costs incurred by hospitals and physicians for patient care services provided to Medicaid and Uninsured patients that are not reimbursed through the claims adjudication process or by other supplemental payments. All UC payments to providers and all expenditures described as UC permissible expenditures must not exceed the cost of services provided to Medicaid and Uninsured patients as defined and discussed in the UC protocol.
- These unreimbursed Medicaid and Uninsured costs are determined based on one of two UC tools depending on the type of entity (hospital or physician) incurring the cost. These tools have been approved by the Centers for Medicare and Medicaid Services (CMS).

Overview

- All costs and other data reported on the initial UC Application will be for the period from October 1, 2009 through September 30, 2010.
- If cost reporting period or accounting fiscal period "straddles" September 30, will need to pro-rate costs and other data from two fiscal periods.
- Either months or days can be utilized to pro-rate costs and other data.

Overview

- Example of Pro-Rating

Assume FYE is December 31						
Fiscal Period			Months	% to Total	Days	% to Total
10/1/2009 - 12/31/2009			3	25.00%	92	25.21%
1/1/2010 - 9/30/2010			9	75.00%	273	74.79%
Total			12	100.00%	365	100.00%

Overview

- Deadline for submission of the UC Application for DY1 is August 31, 2012.
- The UC Application must be received by end of business (5:00 PM CDT) by HHSC.

Overview

- Costs to be included in the Hospital UC Application
  - Physician costs related to direct patient care services
  - Mid-level professional costs related to direct patient care services
  - Pharmacy costs related to the "Texas Vendor Drug" program
  - Excess "Medicaid DSH" costs not reimbursed via the Medicaid DSH program

Overview

- Costs to be included in the Physician UC Application
  - Physician costs related to direct patient care services
  - Non-capital equipment and supplies costs
  - Indirect costs via a provider-specific indirect cost rate
- Costs related to Mid-level professionals must NOT be included in the UC Application

Overview

- A reconciliation will be performed to determine the difference between the costs utilized for interim UC payment purposes and the actual costs applicable to the demonstration year.
- For hospitals, this will involve a two step process, an interim reconciliation based on the filed cost report data, and a final reconciliation based on the final settled cost report data.

Overview

- Reconciliation Example
  - DY1 is the period 10/1/2011 – 9/30/2012. The costs utilized for interim UC payment purposes is the period 10/1/2009 – 9/20/2010.
  - DY3 is the period 10/1/2013 – 9/30/2014. The costs utilized for DY3 interim UC payment purposes is the period 10/1/2011 – 9/30/2012
  - The costs per the UC Application for DY3 will be compared to the costs utilized for interim UC payments made for DY1 and a tentative/final settlement will be made

Hospital UC Application (TXHUC)

- Hospital UC Application consists of:
  - Certification
  - Summary of Costs Schedule
  - Schedule 1 – Computation of UC physician and mid-level professional costs
  - Schedule 2 – Computation of UC Pharmacy costs related to the Texas Vendor Drug program
  - Schedule 3 – Computation of excess hospital Medicaid DSH costs
  - 2011DSH and Cost Report Collection Form – Medicaid DSH Application

TXHUC - Certification

- Must be signed & dated by an officer or administrator of the provider.
- Must be an original signature; not a copy or an electronic signature.
- If an initial submission, appropriate box must be checked.
- Similar to certification page in Medicare cost reports.

TXHUC – Summary Schedule

- Summarizes UC costs from Schedules 1, 2 & 3
- Allows for adjustments to these costs based on actual information applicable to the demonstration year.

TXHUC – Schedule 1

- Column 1 - Physician & Mid-Level Professional Costs
  - Compensation-related costs incurred by the hospital for direct patient care services provided by physicians and mid-level professionals to its patients
  - Mid-level professionals consist of: certified registered nurse anesthetist, nurse practitioner, physician assistant, dentist, certified nurse midwife, clinical social worker, clinical psychologist, optometrist.

TXHUC – Schedule 1

Mid-level professionals consist of:

- Certified Registered Nurse Anesthetist
- Nurse Practitioner
- Physician Assistant
- Dentist
- Certified Nurse Midwife
- Clinical Social Worker
- Clinical Psychologist
- Optometrist

TXHUC – Schedule 1

- The physician and mid-level professional compensation-related costs are incurred and paid by the hospital and excluded from their allowable costs reported on the Medicare cost report via:
  - Reported as Professional Component/Remuneration on w/s A-8-2
  - Reported as professional component directly on w/s A-8
  - Reported in a nonreimbursable cost center on w/s A
  - Not reported on the Medicare cost report

TXHUC – Schedule 1

- Costs for physicians and mid-level professionals may be combined on the same line or reported separately (lines can be subscripted).
- Costs should include all compensation paid related to the physicians and/or mid-level professional patient care services (salaries, contract fees, fringe benefits, malpractice insurance, etc.).

TXHUC – Schedule 1

- If physician and/or mid-level professional costs were reported and excluded from a General Service cost center(s) on the Medicare cost report, the costs should be combined and reported on the General Services line (line 1) of Schedule 1.

TXHUC – Schedule 1

- If non-direct patient care physician costs were excluded from allowable costs on the Medicare cost report due to lack of a time study to allocate the costs between provider and professional component and/or apply the Medicare Reasonable Compensation Equivalents (RCEs), hospitals can claim the provider component portion of these costs as physician costs on the UC application for cost reporting periods beginning prior to 10-1-2012 if certain requirements are satisfied.

TXHUC – Schedule 1

- For cost reporting periods beginning prior to 10-1-2012, the hospital must obtain a "proxy" from the physician indicating the amount of time spent on patient care activities and hospital administrative activities for which they received compensation from the hospital.
- The proxy will be utilized to allocate the physician costs for provider and professional component and the application of the Medicare RCEs to the provider component portion of the costs.

TXHUC – Schedule 1

- Effective for cost reporting period beginning on or after October 1, 2012, the hospital must obtain quarterly time studies from the physician to allocate the physician's compensation costs between provider and professional component and apply the Medicare RCEs on the Medicare cost report.
- CMS-approved time study form must be completed for two weeks each quarter and not the same two weeks in any given quarter.

TXHUC – Schedule 1

- The costs related to the physician's professional component and the provider component costs up to the RCE limit should be reported as physician costs on the UC application for cost reporting periods beginning prior to 10-1-2012.
- For cost reporting periods beginning on or after 10-1-2012, only physician's professional component costs are to be included in the UC application. Physician's provider component costs should be included in the hospital's Medicaid DSH application.

TXHUC – Schedule 1

- The recommended apportionment statistic is billed professional charges by department.
- If a hospital does not maintain billed professional charges by payer, billed hospital departmental charges may be used as the apportionment statistic.
  - Total departmental charges should be based on the charges reported on w/s C of the Medicare cost report(s).

TXHUC – Schedule 1

- The apportionment statistic for physician/mid-level professional costs reported on the General Services line (line 1) are the total professional charges for the hospital.
- If hospital departmental charges are utilized as the apportionment statistic, then the apportionment statistic for the costs reported on the General Services line are total hospital departmental charges.

TXHUC – Schedule 1

- If the hospital's cost reporting period straddles September 30, the apportionment statistics must be pro-rated using the same methodology utilized to pro-rate the physician and/or mid-level professional costs.
- The apportionment statistics should be should be representative of the same time period as the costs (October 1 – September 30)

TXHUC – Schedule 1

- The apportionment statistics must be reported separately for inpatient and outpatient services and by payer category in the applicable columns;
  - Medicaid Fee-For Service (FFS)
  - Medicaid Managed Care (HMO)
  - Uninsured

TXHUC – Schedule 1

- All revenues received by the hospital related to these physician/mid-level professional services (except grant revenue) must be reported on line 102 and will reduce the costs claimed on the UC application.
  - Medicaid program payments
  - Copays or other payments received from the patient or payer
  - Subsidies

TXHUC – Schedule 2

- Schedule computes the pharmacy costs related to prescription drugs provided by the hospital through the Texas Vendor Drug Program.
- If these pharmacy costs were included in the hospital's Texas Medicaid DSH application, they should not be included in the hospital's UC application.

TXHUC – Schedule 2

- Column 1 contains the total costs for the cost center where the pharmacy costs related to the prescription drugs provided under the Texas Vendor Drug Program are reported per the Medicare cost report(s).
- These costs should be based on the total hospital costs reported in the last column of Worksheet B, Part I of the Medicare cost report(s) for the applicable cost center.

TXHUC – Schedule 2

- Total hospital departmental charges reported in Column 1a should be the charges reported for the applicable cost center on w/s C, Part I, column 8 of the Medicare cost report(s).
- The apportionment statistical basis (e.g. hospital departmental charges) should be identified in column 1b.

TXHUC – Schedule 2

- Charges related to the prescription drugs under the Texas Vendor Drug program for the various payer types are reported in the respective columns.
  - These charges should be supported by the hospital's internal records.
- If the hospital's cost reporting period straddles September 30, the costs and other data reported on this schedule should be pro-rated utilizing the same methodology utilized to pro-rate the costs and other data on Schedule 1.

TXHUC – Schedule 2

- All revenues received by the hospital related to these prescription drugs must be reported on line 2 and will reduce the costs claimed on the UC application.
  - Vendor drug rebates
  - Copays or other payments received from the patient or payers

TXHUC – Schedule 3

- The schedule determines the hospital's Medicaid DSH costs in excess of the DSH program payments received for inclusion in the UC application.
- The schedule requires no input from the hospital. It will be completed by Texas HHSC staff based on the hospital's DSH application and program payments made by HHSC.

TXHUC – Schedule 3

- If the hospital completed and submitted a Texas Medicaid DSH application but did not receive any Medicaid DSH program payments, HHSC will determine the hospital's Medicaid DSH costs based on their submitted DSH application utilizing the same methodology employed for hospital's who did receive Medicaid DSH program payments for inclusion in their UC application.

TXHUC – Schedule 3

- If the hospital did not submit a Texas Medicaid DSH application to HHSC, the hospital should complete the Medicaid DSH forms (2011DSH & Cost Report Collection Form) which are included in the TXHUC model and submit them with their UC application. Also included are the instructions for the completion of the Medicaid DSH application.

TXHUC – Schedule 3

- HHSC will determine the hospital's Medicaid DSH costs based on their submitted DSH application utilizing the same methodology employed for hospital's who did receive Medicaid DSH program payments for inclusion in their UC application.

Physician UC Application (TXPUC)

- Physician UC Application Consists of:
  - Certification
  - Cost Summary – Summary of UC costs
  - Worksheet A – Summary of allowable physician costs
  - Worksheet A-6 – Reclassification of costs
  - Worksheet A-8 – Adjustments to costs
  - Worksheet B – Computation of cost-to-charge ratio
  - Worksheet D – Apportionment of physician costs

TXPUC - Certification

- Must be signed & dated by an officer or administrator of the organization.
- Must be an original signature; not a copy or an electronic signature.
- If an initial submission, appropriate box must be checked.

TXPUC – Cost Summary

- Summarizes UC costs from Schedule D
- Allows for adjustments to these costs based on actual information applicable to the demonstration year.

TXPUC – Worksheet A

- Determines allowable physician costs related to direct patient care services provided in all settings (hospital, physician clinic, etc.).
- Physician costs reported in column 1 are computed on w/s A-1 and flow to w/s A.
- Column 2 is not utilized at this time.

TXPUC – Worksheet A

- Column 3 includes costs for non-capital equipment and supplies.
- Non-capital equipment would include but are not limited to:
  - Reusable surgical trays, scalpels or other medical equipment whose costs are expensed upon acquisition and not capitalized
- Supplies would be items such as disposable supplies utilized during the treatment of patients:
  - Sutures, bandages, syringes & needles, splints, etc.

TXPUC – Worksheet A

- Column 5 contains any reclassification of costs as identified on w/s A-6. These costs must be manually entered from w/s A-6 in column 5.
- Column 7 contains any adjustment of costs as identified on w/s A-8. These costs must be manually entered from w/s A-8 in column 7.
  - If costs for mid-level professionals are reported in column 1, they should be excluded on w/s A-8.

TXPUC – Worksheet A

- Column 8 computes the indirect costs for each cost center based on the costs in column 6 multiplied by the indirect cost rate at the top of w/s A.
- The indirect cost rate is determined on an annual basis for each professional organization based on the organization's actual indirect costs.

TXPUC – Worksheet A

- If the professional organization's accounting fiscal period does not coincide with the reporting period of the UC application, the indirect cost ratio for the two periods should be weighted based on the number of months for each period included in the UC application period.
- Direct and indirect costs will be based on the organization's general ledger for the applicable period(s).

TXPUC – Worksheet A

- Direct expenses are comprised of the total physician costs from w/s A, column 1 plus the total non-capital equipment and supplies costs from column 3.
- If the costs for mid-level professionals are included in column 1, they should be excluded from direct costs for the computation of the indirect cost rate. Any non-capital equipment and supplies costs reported in column 3 related to mid-level professionals should also be excluded from direct costs for the indirect cost rate computation.

TXPUC – Worksheet A

- Indirect costs are determined utilizing Medicare cost finding principles
- Indirect costs would include but are not limited to:
  - Nurse staff, other support personnel, billing and administrative costs.
  - Space costs such as building and equipment depreciation or lease expense, utilities, taxes, etc.
- Fringe benefit costs related to physician compensation should be included as physician costs in column 1 and not included in indirect costs.

TXPUC – Worksheet A

- Nonallowable indirect costs would include but are not limited to:
  - Bad debts on accounts receivable.
  - Gain or loss on the sale of depreciable assets
  - Fines and penalties imposed by local, state or federal government or their agencies.
  - Advertising for the purpose of increasing patient utilization.

TXPUC – Worksheet A

UC application reporting period	10/1/2009 - 9/30/2010	
Fiscal year end of professional organization	12/21/2009	12/31/2010
Total expenses per the general ledger	25,000,000	28,600,800
Bad Debts	(800,000)	(923,000)
Loss on sale of depreciable assets	(200,000)	(123,000)
N/A Advertising expenses	(111,000)	(133,000)
Mid-Level Professional compensation	(2,435,000)	(2,679,000)
Physician compensation (from col. 1)	(11,500,700)	(13,600,200)
Non capital equipment and supplies (from col. 3)	(765,000)	(842,000)
Allowable Direct Expenses	(12,265,700)	(14,442,200)
Allowable indirect costs	9,188,300	10,300,600
Total direct costs (allowable + nonallowable)	15,811,700	18,300,200
Indirect cost ratio	58.11%	56.29%
Weighted indirect cost ratio	14.53%	42.22%
Allowable indirect cost ratio		56.74%

TXPUC – Worksheet A-1

- Determines the physicians' compensation costs for direct patient care services
- Costs are reported by physician specialty based on the location where the patient care services were rendered
  - Hospital
  - Non-Hospital (physician clinic or office)
  - Other (nursing home, hospice, etc.)

TXPUC – Worksheet A-1

- Physician compensation costs are comprised of:
  - Salaries and employee fringe benefits.
  - Payment to the physician under a contractual arrangement with the professional organization.
  - Retirement and/or deferred compensation costs
  - Health and/or long term disability insurance costs.
  - Malpractice insurance costs.

TXPUC – Worksheet A-1

- If the compensation payments made to the physician by the professional organization are only for direct patient care services, then the costs can be input directly in column 1 on w/s A and w/s A-1 does not need to be completed.
- If the compensation payments made to the physician are for direct patient care and administrative services and the professional organization has a time study to allocate the costs between the patient care and other activities, the percentage of patient care time can be applied to the total physician compensation and input directly in column 1 on w/s A. W/s -1 would not need to be completed.

TXPUC – Worksheet A-1

- If the professional organization pays the physician for direct patient care and administrative or other activities (e.g. teaching), and a time study does not exist to allocate the physician costs to the various activities, the patient care portion of the costs will be determined via w/s A-1 through the application of the physician's work RVUs (relative value units) prior to 10-1-2012.

TXPUC – Worksheet A-1

- The physician(s) actual work RVUs for the period are reported in column 1.
- The benchmark work RVUs based on the physician's specialty from the Benchmark RVU worksheet are reported in column 2.
- The percentage of the actual work RVUs to the benchmark work RVUs is computed in column 3.

TXPUC – Worksheet A-1

- The physician's total compensation for the period is reported in column 4.
- The allowable physician patient care cost is determined in column 5 by multiplying the percentage computed in column 3 by the physician compensation in column 4. The costs will flow to w/s A, column 1.

TXPUC – Worksheet A-1

- Effective on or after 10-1-2012, if the professional organization pays the physician for direct patient care and administrative or other activities (e.g. teaching), time studies based on the form approved by CMS must be utilized to allocate the physician costs to the various activities and the patient care portion of the cost should be input directly on w/s A, column 1.

TXPUC – Worksheet A-1

- A time study should be completed for two weeks per quarter and not the same two weeks in any given quarter.
- The time study should include time for all activities the physician receives payment for from the professional organization.
- The patient care time and total time from the four quarterly time studies would be summed to compute the patient care ratio.

TXPUC – Worksheet A-1

Example of Patient Care Percentage Computation

Time Study Quarter	Patient Care	Admin	Teaching	Total
10/1 -12/31	465	100	125	690
1/1 - 3/31	510	65	110	685
4/1 - 6/30	480	85	95	660
7/1 - 9/30	500	70	115	685
Total	1,955	320	445	2,720
% to Total	71.88%			

TXPUC – Worksheet A-6

- If costs need to be reclassified from one cost center(s) to another(s) cost center, a brief explanation should be reported in column 1.
- The applicable cost center(s) should be reported in column 2 & 6 respectively.
- The costs to be reclassified should be reported in columns 4,5 & 8,9 respectively. The costs should be identified as salary or other.
- All reclassifications must be input into w/s A, column 5.

TXPUC – Worksheet A-8

- If adjustments to the costs need to be made, a brief explanation should be reported in "Explanation of Adjustment(s) column.
- The applicable cost center(s) should be reported in column 2.
- The adjustment(s) to the costs should be reported in columns 4 & 5 respectively. The costs should be identified as salary or other.
- All adjustments must be input into w/s A, column 7.

TXPUC – Worksheet B

- Determines the cost-to-charge ratio for use in the apportionment of costs on w/s D.
- The allowable physician costs from w/s A, column 9 will flow to column 1.
- The total billed professional charges by physician specialty and service location are reported in column 2. These charges should for the same time period as the costs.

TXPUC – Worksheet D

- Apportions the physician costs to the various payers by physician specialty and service location.
- The cost-to-charge ratio determined on w/s B, column 3 will flow to column 1.
- Physician patient care charges for inpatient and outpatient services provided to patients in the various payer categories by physician specialty and service location are reported in columns 2 – 7.

TXPUC – Worksheet D

- Physician costs to be included in the UC application are computed in columns 8 - 13 by multiplying the cost-to-charge ratio in column 1 by the charges reported in columns 2 – 7.
- Any revenue received by the organization (except grant revenue) related to these physician costs should be reported on line 81 for columns 8 – 13.
  - Copayments
  - Subsidies

TXPUC – Worksheet D

- The net physician costs determined for columns 8 – 13 on line 82 will flow to the Cost Summary worksheet.