Public Health Provider - Charity Care Program (PHP-CCP) for Governmental Entities

Cost Report Training for Federal Fiscal Year 2023

Housekeeping Items

If you experience any technical difficulties, please contact Webinar Support at 1-800-263-6317.

Training duration is approximately two hours.

A short break will be provided.

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PHP-CCP@hhs.texas.gov

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Housekeeping Items

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- The system tracks attention levels. Be sure to move your mouse and type questions in the chat box. Logging out early will disqualify today's attendance.
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Website & Email

You can access the Texas Health and Human Services Provider Finance Department’s Acute Care webpage by following the link below:

https://pfd.hhs.texas.gov/acute-care

https://pfd.hhs.texas.gov/acute-care/public-health-provider-charity-care-program

If you have problems accessing the link, copy the address to your web browser, which will take you directly to the webpage.

Send Cost Report Questions to the following email box: PHP-CCP@hhs.texas.gov

GovDelivery Updates

As HHSC shifts to official communications via GovDelivery, please register via the link to receive relevant and timely information from HHSC.

To create an account:

https://service.govdelivery.com/accounts/TXHHSC/subscriber/new

Texas Administrative Code References

355.101-107	Cost Determination Process
355.110	Informal Reviews and Formal Appeals
355.8217	Payments to Public Health Providers for Charity Care

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Year 1 (Demonstration Year 11) to Year 2 (Demonstration Year 12)

Year 1 (DY11) to Year 2 (DY12)

	Year 1 (DY11)	Year 2 (DY12)
Eligible for Reimbursement	Medicaid Shortfall and Uncompensated Care	Charity Care Only
Required Documents	Cost Report, Supporting Documentation	Cost Report, Supporting Documentation, Charity Care Policy
Total Funding	$500 Million	$500 Million
Cost Report Period	October 1, 2021 – September 30, 2022	October 1, 2022 – September 30, 2023
Last Day to Submit Cost Report to HHSC	November 14, 2022	November 14, 2023

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Overview & Participation

Eligibility for Participation

To participate, a provider must:

- Indicate it is a qualifying provider
- Attend PHP-CCP financial training and receive credit
- Submit an annual PHP-CCP cost report by the due date and must certify costs in a manner specified by HHSC
- Certify that no part of the PHP-CCP payment will be used to pay a contingency fee

TAC §355.8217

Qualifying Providers

Qualifying providers must be able to certify public expenditures and will be paid an annual lump sum based upon actual expenditures.

Publicly-owned and operated providers eligible to participate include the following:

- Providers established under the Texas Health and Safety Code Chapters 533 or 534 and primarily providing behavioral health services
  - Community Mental Health Clinics (CMHCs)
  - Community Centers
  - Local Behavioral Health Authorities (LBHAs)
  - Local Mental Health Authorities (LMHAs)
- Local Health Departments (LHDs) and Public Health Districts (PHDs) established under the Texas Health and Safety Code Chapter 121

TAC §355.8217

Financial Assistance Policy –

Charity Care

Financial Assistance Policy – Charity Care

- Providers' charity care and financial assistance policies must be defined for the submitted cost reporting year and submitted with the Year 2 Cost Report and supporting documentation.
- The policy must follow the guidelines illustrated in the Healthcare Financial Management Association (HFMA):
  - Sample 501(c)(3) Hospital Charity Care & Financial Assistance Policy & Procedures and
  - Valuation and Financial Statement Presentation of Charity Care, Implicit Price Concessions, and Bad Debts by Institutional Healthcare Providers.

Financial Assistance Policy – Charity Care

A comprehensive policy (no length requirement) would include:

- Charity Care and Uninsured Related Definitions
- Effective Date (applicative to cost reporting period)
- Eligibility Criteria
- Eligibility Determination Methodology
- Community Communication Plan
- Regulatory Requirements
- List of Participating Providers

Effective Date

The Financial Assistance Policy must include the policy’s effective date (date must be on or before the first day of the cost reporting period).

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Eligibility Criteria Examples

- Individual or family income
- Individual or family net worth
- Employment status
- Other financial obligations
- Amount and frequency of healthcare bills
- Other financial resources available to the patient

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Eligibility Determination Methodology

Determining the amount of charity care for which a patient is eligible is largely based on information supplied by the patient or someone acting on the patient's behalf.

The charity care policy should address eligibility for charity care when the patient has insufficient information to fully evaluate all the criteria and the ability to pay cannot be reliably determined. Policies may refer to external sources such as credit reports or Medicaid enrollment to help support such determinations.

Eligibility Determination Methods

- Include an application process
- Include the use of external publicly available data sources
- Include reasonable efforts by the provider to explore appropriate alternative sources
- Consider assets
- Review other accounts from patient

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Community Communication Plan

When gathering financial information, providers should follow the guidelines and principles outlined in the HFMA Patient Friendly Billing project and Patient Financial Communication Best Practices to ensure their financial communications are:

- Clear
- Concise
- Correct
- Considerate of the needs of patients and family members

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- Focus on compassion
- Define policies
- Hold annual staff training
- Conduct patient conflict resolution via face-to-face discussions with Registration/Discharge staff
- Offer patient support

Best Practices for Financial Communications (cont'd)

- Refer to a financial counselor
- Ensure that financial discussions do not interrupt patient care
- Communicate
- Conduct patient surveys
- Respect patient privacy

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Regulatory Requirements

In implementing this policy, provider management and facilities shall comply with all other federal, state, and local laws, rules, and regulations that may apply to activities conducted under this Policy.

List of Participating Providers

The Financial Assistance Policy must include or link to a list of all providers/entities encompassed by the Policy.

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Cost Report – Overview

Cost Report – Overview

A provider must prepare and complete a Public Health Provider Cost Report (cost report) annually.

- The provider must submit the cost report to HHSC
- A cost report period begins on October 1 and ends on September 30 of the following year

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Cost Report – Overview

Current PHP-CCP Methodology:

FFY/DY	Report Service Period	Report Due Date
FFY 2023/DY12	10/01/2022 – 09/30/2023	11/14/2023
FFY 2024/DY13	10/01/2023 – 09/30/2024	11/14/2024

FFY: Federal Fiscal Year; DY: Demonstration Year

All important information, notices, due dates, etc. can be found on the following website: https://pfd.hhs.texas.gov/acute-care/public-health-provider-charity-care-program

Cost Report Training Requirements

HHSC provides annual PHP-CCP financial training to participating qualifying providers.

- A PHP-CCP financial contact must attend training for each program period
- Multiple individuals from a qualifying provider may attend
- Training is provided for each program period
- The qualifying provider must attend training annually
- A provider that does not have a trained PHP-CCP financial contact is prohibited from submitting a PHP-CCP cost report
- Provider-contracted vendors are permitted to enter a provider’s data

Cost Report – Overview

Cost Report Preparation & Certification

- An eligible and participating provider will prepare the cost report
- Costs are only eligible to be reimbursed within 24 months after the date that the cost was incurred

Cost Report Expenditures

- The cost report will include only allocable expenditures
- The cost report may not include costs for services delivered to persons who are incarcerated at the time of the service or costs for services delivered by an Institution for Mental Diseases.

Cost Report – Definitions

PHP-CCP Cost Report Definitions

Charity Care: Healthcare services provided without expectation of reimbursement to uninsured patients who meet the provider's charity-care policy.

Cognizant agency: Agency responsible for reviewing, negotiating, and approving cost allocation plans.

Cost Allocation Plans: How costs are identified in a logical and systematic manner for reimbursement.

PHP-CCP Cost Report Definitions

Cost-to-Charge ratio:

$$\text{Cost-to-Charge Ratio} = \frac{\text{Total Allowable Cost Reported}}{\text{Billed Charges of All Medical Claims}}$$

PHP-CCP Cost Report Definitions

Direct Cost: Costs incurred by a provider that are attributable to the operation of providing contracted client services. All costs identified specifically with other final cost objectives of the contractor are direct costs of those cost objectives.

Federal Medical Assistance Participation (FMAP) Rate: The share of state Medicaid benefit costs paid for by the federal government.

Indirect Costs: These are costs incurred identified with two or more cost objectives but not specifically identified with any final cost objective.

Indirect Cost Rate: This rate is to reasonably determine the proportion of indirect costs each program should bear. It is the ratio, expressed as a percentage, of the indirect costs to the direct costs.

PHP-CCP Cost Report Definitions

Medicaid Fee-For-Service (FFS) Paid Claims: These claims are Medicaid payments made by HHSC through the Texas Medicaid Healthcare Partnership to enrolled providers for services provided to Medicaid recipients.

Medicaid Managed Care: Medicaid Managed Care delivers Medicaid health benefits and additional services through an arrangement between a state Medicaid agency and managed care organizations (MCOs) that accept a set payment for these services. The MCOs make Medicaid payments to providers for services provided to Medicaid recipients.

Medicare: Medicare is a federal system of health insurance for people over 65 years of age and for certain younger people with disabilities.

PHP-CCP Cost Report Definitions

Other third-party coverage:

Commercial Pay Insurance: Commercial Pay Insurance is health insurance that covers medical expenses and disability income for the insured. Commercial health insurance can be categorized according to its renewal provisions and the type of medical benefits provided. Commercial policies can be sold individually or as part of a group plan.

Self-Pay: A self-pay patient pays in full at the time of visit for services and does not file a claim with an insurance carrier

PHP-CCP Cost Report Definitions

Total Computable Amount: The Total Computable Amount is the total Medicaid allowable amount payable for services before any reductions for interim payments.

Uninsured: An individual who has no health insurance or other source of third-party coverage for medical/health services.

PHP-CCP Cost Report Definitions

Uninsured cost: Uninsured Cost is the cost to provide services to uninsured patients as defined by the Centers for Medicare and Medicaid Services (CMS). HHSC considers an individual whose third-party coverage does not include the service provided to be uninsured for that service.

Unit of Government: A state, city, county, special purpose district, or other governmental units in the State that: has taxing authority, direct access to tax revenues, is a State university teaching hospital with direct appropriations from the State treasury, or is an Indian tribe as defined in Section 4 of the Indian Self-Determination and Education Assistance Act, as amended, 25 U.S.C. 450b.

Submission, Reviews & Appeals

Cost Report Submission/Review Process

- HHSC submits a SAR (State-Action Request) to TMHP in order to receive all prudent claims data pertaining to each provider for the corresponding reporting period
    - Only claims data for approved procedure codes for that provider type is pulled.
- HHSC conducts a desk reviews on each cost report
- HHSC completes reviews within 60 days of cost report submission

Desk Reviews

Providers are responsible to respond to HHSC Provider Finance staff within 15 days from the date HHSC requests clarification and/or additional information.

Records must be accessible to HHSC staff within 10 working days of notification.

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Common Desk Review Findings

- Documentation does not support services rendered
- Documentation does not include billable time
- Documentation does not include start and stop times, total minutes, activity performed, or related objectives (Time Sheets)
- Amount of time billed does not match the amount of time documented
- Documentation does not support costs reported on cost report
- Depreciation calculations, formulas, cost-basis data, etc. are missing
- Providers include unallowable claims in FFS and MCO charges and payments

Informal Review Requests

- Due within 30 calendar days of notification.
- Must include items in dispute, recommended resolution, and supporting documentation.
- Must be signed by an individual legally responsible for the conduct of the contracted provider or their legal representative.

TAC 355.110

Appeal Process

If a governmental entity does not agree with the decision made by HHSC-PFD, the entity has an option to file an appeal through the HHSC appeal process.

Formal appeals are conducted in accordance with Title 1 Texas Administrative Code Section 357 (relating to Hearings under the Administrative Procedure Act).

Requests for a formal appeal from the interested party must be received within 15 calendar days after the interested party receives the written decision.

Requests must be sent directly to:
HHSC Appeals Division
Mail Code W-613
P.O. Box 149030
Austin, Texas 78714-9030

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TAC 357

Medicaid Records Retention Policy

State laws generally govern how long medical records must be retained. However, the Health Insurance Portability and Accountability Act of 1996 administrative simplification rules require a covered entity, such as a physician billing Medicare, to retain required documentation for six years from the date of its creation or the date when it last was in effect, whichever is later. HIPAA requirements preempt State laws if they require shorter periods. Your State may require a longer retention period. HIPPA policies and procedures and documentation requirements can be found at 45 CFR 164.316(b)(2)(i)-(iii).

The Centers for Medicare & Medicaid Services (CMS) requires records of providers submitting cost reports to be retained in their original or legally reproduced form for a period of at least five years after the closure of the cost report. This requirement is available at 42 CFR 482.24(b)(1).

Provider Finance Mailing Addresses

Regular Delivery
HHSC Provider Finance
Mail-Code H-400
P.O. Box 149030
Austin, TX 78714-9030

Courier Service / Special Delivery
HHSC Provider Finance
4601 W Guadalupe St
Austin TX, 78751
Mail Code H-400

Closing Remarks