

Health and Human Services Commission (HHSC)
Dental Services Supplemental Payment Program Cost Report
Instructions (Revised 11-08-2022)

INSTRUCTIONS FOR COMPLETING THE DENTAL SERVICES SUPPLEMENTAL PAYMENT PROGRAM COST REPORT

General:

Governmentally owned dental providers are eligible to participate in the supplemental payment program if directly funded by a unit of government such as a local government, hospital authority, hospital authority, hospital district, city, county, or state, as specified in 42 CFR §433.50 (i). This funding category also includes providers such as public health clinics and departments, dental schools, mobile dental units, or other dental facilities that are owned by the government. Providers wanting to participate in the program should contact the Texas Health and Human Services Commission (HHSC), Provider Finance Department at the Provider Finance Department Hospitals mailbox at pfd_hospitals@hhsc.state.tx.us. The cost report will include only allocable expenditures related to Uninsured Charity Care as defined and approved in the Texas Healthcare Transformation and Quality Improvement 1115 Waiver Program. The Dental Services Supplemental Payment Cost Report (cost report) must be prepared and completed on an annual basis for federal fiscal years ending on September 30. Cost reports are due to HHSC 180 days after the close of the applicable reporting period. An eligible provider approved to submit a cost report for supplemental payment will prepare the cost report, attest to, and certify the total actual Uninsured Charity Care costs/expenditures.

The completed cost report will be sent to: pfd_hospitals@hhsc.state.tx.us

When using the Excel spreadsheet, many fields in the worksheets will automatically populate with information from another worksheet to avoid additional data entry and reduce errors. Therefore, only the SHADED AREAS of the cost report should be completed. Please review and verify the accuracy of all information in the worksheets before completing the report. For questions on completing the cost report, please contact the Health and Human Services Commission, Provider Finance Department at pfd_hospitals@hhsc.state.tx.us.

Definitions:

Cognizant agency — the agency responsible for reviewing, negotiating, and approving cost allocation plans or indirect cost proposals developed under the Office of Management and Budget Circular A-87.

Commercial Pay Insurance — 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.

Cost Allocation Plans — are how costs are identified in a logical and systematic manner for reimbursement under federal grants and agreements.

Cost-to-charge-ratio (CCR) — a provider's reported costs are allocated to the uninsured charity care based on a cost-to-billed-charge ratio. The cost-to-billed charge ratio is calculated as the total allowable cost reported for the service period divided by total billed charges for the service period. This ratio is then applied to

the total billed charges associated with Medicaid paid claims to calculate the total allowable billed charges for the cost report.

Direct Cost — means any cost specifically identified with a particular final cost objective. Direct costs are not limited to items that are incorporated in the end product as material or labor. Costs identified specifically with a contract are direct costs of that contract. All costs identified specifically with other final cost objectives of the contractor are direct costs of those cost objectives.

Federal Medical Assistance Percentage (FMAP) — the share of state Medicaid benefit costs paid for by the federal government.

Indirect Costs — costs incurred and identified as having two or more cost objectives but not specifically identified with any final cost objective.

Indirect Cost Rate — the ratio, expressed as a percentage, of the indirect costs to the direct costs, determining the proportion of indirect costs each program should reasonably bear.

Intergovernmental Transfers (IGT) — State and local funds derived from taxes, assessments, levies, investments, and other public revenues within the sole and unrestricted control of a governmental entity and eligible for federal match under the 1115 Transformation Waiver. These funds do not include gifts, grants, trusts, or donations, conditional on being used only to supply a benefit solely to the donor or grantor of the funds.

Medicaid Fee-For-Service (FFS) — the traditional health care payment system, in which providers receive a payment for each unit of service they provide.

Medicaid Managed Care (MCO) — an entity that provides or contracts for managed health care. Medicaid payments are made by the MCOs to providers for services provided to Medicaid recipients.

Medicare — a federal system of health insurance for individuals 65 and older, disabled, or with permanent kidney failure.

Self-Pay — an individual who either does not have insurance, or her or his insurance does not cover a particular procedure or Provider, and therefore, the individual is responsible for paying the Provider.

Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver — approved by HHSC and (Centers for Medicare & Medicaid Services) CMS to implement the waiver program under section 1115 of the Social Security Act.

Uncompensated Care (UC) — costs of uninsured charity care provided to individuals who have no funds or third-party coverage for services provided by medical, dental, or other providers.

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

Uninsured cost — the cost to provide dental services to uninsured patients as defined by the Centers for Medicare and Medicaid Services. An individual whose

third-party coverage does not include the service provided is considered by HHSC to be uninsured for that service.

Unit of government—a state, city, county, special purpose district, or another governmental unit 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).

Cover Page (Tab 1)

The first sheet is the cost report cover page. This form includes a provider's national and state provider identification numbers. Each governmental provider enters its legal name and the appropriate contact information for all parties listed on the form. HHSC will use this information to contact the provider during the cost reconciliation and settlement process.

DIRECTIONS TO COMPLETE the Cover Page

Federal Fiscal Year: Enter the federal fiscal year for which the cost report will be completed (e.g., 2012). When this year is entered on the cover page, this field will automatically transfer to subsequent worksheets.

Reporting Period Start and End Date: Enter the actual reporting period for which the cost report will be completed (e.g., 10/01/11 to 09/30/12). When this period is entered on the cover page, this field will automatically transfer to subsequent worksheets.

Texas Provider Identification Number (TPI): Enter the 9-digit TPI number for the Provider completing the cost report. When this number is entered on the cover page, this field will automatically transfer to subsequent worksheets.

National Provider Identification Number (NPI): Enter the 10-digit NPI number for the Provider that is completing the cost report. When this number is entered on the cover page, this field will automatically transfer to subsequent worksheets.

Provider Information

Provider Name: Enter the Provider's legal name (e.g., Laredo Health Department Dental Clinic)

Provider Contact Name: Enter the Provider's contact.

Street Address: Enter the street address and include the city, state, and zip code in this field.

Mailing Address: Enter the street address and include the city, state, and zip code in this field.

Phone Number: Enter the phone number of the Provider's contact.

Fax Number: Enter the fax number of the Provider's contact.

Email: Enter the email of the Provider's contact.

Chief Financial Officer/Business Manager

Name: Enter the name of the chief financial officer or business manager.

Title: Enter the title of the chief financial officer or business manager.

Business Name: Enter the business name (e.g., UT Health Science Center at San Antonio Dental School).

Mailing Address: Enter the street address and include the city, state, and zip code in this field.

Phone Number: Enter the phone number of the chief financial officer or business manager.

Fax Number: Enter the fax number of the chief financial officer or business manager.

Email: Enter the email of the chief financial officer or business manager.

Report Preparer Identification

Name: Enter the name of the person responsible for preparing the cost report (this is the person HHSC should contact if there are questions).

Title: Enter the title of the report preparer.

Business Name: Enter the business name (e.g., UT Health Science Center at San Antonio Dental School).

Mailing Address: Enter the street address and include the city, state, and zip code in this field.

Phone Number: Enter the phone number of the report preparer.

Fax Number: Enter the fax number of the report preparer.

Email: Enter the email of the report preparer.

Location of Accounting Records that Support this Report

Physical Address: Enter the physical address of the location where the Provider maintains the accounting records that support the cost report and include the city, state, and zip code in this field.

When this information is entered on the cover page, this field will automatically transfer to the subsequent worksheets.

General & Statistical (Tab 2)

DIRECTIONS TO COMPLETE General & Statistical

Worksheet 2 is the General and Statistical Information worksheet of the cost report. This worksheet includes general Provider and statistical information used in the cost report.

General Provider Information

1.00-1.04: These fields will automatically transfer from the Cover Page.

1.05: Enter yes or no to indicate if the reporting period is less than a full federal fiscal year. If the cost report is for a partial fiscal quarter, enter a response that explains why (e.g., no, supplemental payment request approval was effective beginning 3/1/20XX).

Cost Allocation Information

The purpose of this section is to obtain summary information regarding the cost allocation methodology the governmental entity utilized to allocate costs to various programs, grants, contracts, and agreements. Additional information required to support an agency's methodology will be found on Worksheet C.

1.06: Enter yes or no to indicate whether your agency has an approved Cost Allocation Plan (CAP). Additional information must be provided externally.

1.07: If the answer to 1.06 is yes, enter the name of the Cognizant Agency.

1.08: Enter yes or no to indicate whether your agency has an approved Indirect Cost Rate (IDCR).

1.09: If the answer to 1.08 is yes, enter the name of the Cognizant Agency.

1.10: Enter either yes or no to indicate whether your agency will be using an IDCR on this report.

1.11: If the answer to 1.10 is yes, enter the IDCR Statistical Information.

Statistical Information

1.12 Uninsured Charity Care Reimbursement: Enter the amount.

1.13 Uninsured Charity Care Billed Amount: Enter the amount.

1.14: Total Allowable Costs for Reporting Period: This field will automatically transfer from Dental Cost Settlement, 1.47. This amount includes only Medicaid FFS, Medicaid MCO, and Uncompensated Care costs.

1.15: Total Medicaid FFS Billed Charges Amount Associated with Medicaid Paid Claims: Enter the total.

1.16: Total MCO Billed Charges Amount Associated with Medicaid Paid Claims: Enter the total.

1.17: Medicare Charges: Enter the total.

1.18: Charges for Other Third-Party Claims: Enter the total

1.19: Charges for Self-Pay, County/Indigent Recipient Programs: Enter the total.

1.20 All Other Claims within the Reporting Period: Enter the total.

Dental Cost Settlement (Tab 3)

DIRECTIONS TO COMPLETE Dental Cost Settlement

Worksheet 3 identifies and summarizes all dental services costs. Much of the information contained within this worksheet is automatically pulled from other worksheets. However, unique cost items must be entered in this worksheet. Only allocable expenditures related to Uninsured Charity care as defined and approved in the Texas Healthcare Transformation and Quality Improvement 1115 Waiver Program will be included for supplemental payment. Direct cost methods must be used whenever reasonably possible. Direct costing means that allowable costs, direct or indirect, incurred for the benefit of, or directly attributable to, a specific business component must be directly charged to that particular business component.

Direct cost accounting may include:

Dedicated Cost Centers: Cost may be included for those cost centers that are solely dedicated to Uninsured Charity Care.

This worksheet sums the payroll expenses and adds other costs to calculate allowable costs of dental services. Identified reductions are subtracted to calculate the adjusted amount of dental costs allowable as part of the cost report.

The cost report identifies the portion of allowable charges that are related to uninsured charity care, then multiplies these charges by a cost-to-charge ratio based on total facility charges and costs to calculate the allowable uninsured charity care costs within the cost report period. This amount is then reduced by any reimbursement received for uninsured charity patients. The resulting shortfall is the total allowable cost for the facilities' payment. This shortfall is then multiplied by the applicable Federal Medical Assistance Percentage (FMAP) to calculate the Federal and State amounts. Please note that this final amount is subject to a further reduction based on available Uncompensated Care (UC) dollars when the UC payment is calculated. This worksheet is separated into the sections identifying:

Payroll Expenses

1.25-1.26: Total paid hours include but are not limited to regular wage, sick, and vacation hours. These costs will automatically transfer to this worksheet if personnel/payroll expenditure data is entered on Worksheet B, Payroll and Benefits. Support for these items must be provided with the cost report.

1.27: Employer Retirement Contribution: Enter the total. These costs will automatically transfer to this worksheet if personnel/payroll expenditure data is entered on Worksheet B, Payroll and Benefits.

1.28: Employer FICA Payroll Taxes: Enter the total. These costs will automatically transfer to this worksheet if personnel/payroll expenditure data is entered on Worksheet B, Payroll and Benefits.

1.29: Employer Medicare Payroll Taxes: Enter the total. These costs will automatically transfer to this worksheet if personnel/payroll expenditure data is entered on Worksheet B, Payroll and Benefits.

1.30: State Unemployment Payroll Taxes: Enter the total (if applicable). These costs will automatically transfer to this worksheet if personnel/payroll expenditure data is entered on Worksheet B, Payroll and Benefits.

1.31: Federal Unemployment Payroll Taxes: Enter the total (if applicable). These costs will automatically transfer to this worksheet if personnel/payroll expenditure data is entered on Worksheet B, Payroll and Benefits.

1.32: Unemployment Compensation (Reimbursing Employer): Enter the total (if applicable). These costs will automatically transfer to this worksheet if personnel/payroll expenditure data is entered on Worksheet B, Payroll and Benefits.

1.33: Total Staff Costs: Will automatically calculate (sum of applicable items in 1.25-1.32).

Other Costs

1.34 a.-b.: Supplies and Materials: Supplies and materials include but are not limited to dental and medical supplies, office supplies, and maintenance supplies. Supplies and materials must be separated according to whether they are non-clinical or clinical.

The total for non-clinical supplies and materials would be entered in 1.35 a.

The total for clinical supplies and materials would be entered in 1.35 b.

Details describing the supplies and materials with the amount and allocation methodology should be attached as a separate sheet. Additional administrative (non-clinical) costs will not be permitted if a cognizant agency-approved indirect cost rate is used.

1.36: Equipment: Equipment costs include but are not limited to dental and medical equipment, computers, and communication equipment. Equipment costs must be separated according to whether they are non-clinical or clinical.

The total for non-clinical equipment would be entered in 1.37 a.

The total for clinical equipment would be entered in 1.37 b.

Details describing the equipment costs with the amount and allocation methodology should be attached as a separate sheet. Additional administrative (non-clinical) costs will not be permitted if a cognizant agency-approved indirect cost rate is used.

1.38: Support Services: Enter the total and provide details attached on a separate sheet. Support services expenditures may include personnel and non-personnel expenditures such as information technology salaries, benefits, and operating expenditures.

1.39: Other: Enter the total and provide details on an external sheet.

1.40: Depreciation: Depreciation information should first be entered on Schedule A. Depreciation will automatically transfer to this line.

1.41: Total Direct and Indirect Dental Other Costs: Will automatically calculate (sum of 1.34 through 1.40).

1.42: Total Staff, Direct, and Indirect Dental Other Costs: Will automatically calculate (sum of 1.33 and 1.41).

Reductions

1.43: Other Federal Funds and Grants: If expenditure data is entered on Worksheet B, Payroll and Benefits, those costs will automatically transfer to this line.

1.44: Other: Enter the total as a positive number and provide detail in an external document.

1.45: Total Reductions: Will automatically calculate (sum of 1.43 and 1.44).

Cost Settlement Calculation

1.46: Total Billed Charges: This field is a sum calculation that will automatically populate from the General & Statistical worksheet (1.13, 1.15-1.20).

1.47: Total Allowable Costs: Will automatically calculate (1.42 less 1.45).

1.48: Cost-to-Charge-Ratio (CCR) = Total Allowable Costs/Total Billed Charges: Will automatically calculate (1.47 divided by 1.46).

1.49: Total Billed Charges Associated with Uninsured Charity Care: This field will automatically transfer from General & Statistical, (1.13).

1.50: Uninsured Charity Care Cost: The calculation of costs for Uninsured Charity Care – Will automatically multiply the Cost to Charge Ratio (1.48) by the Total Billed Charges Associated with Uninsured Charity Care Cost Claims (1.49).

1.51: Minus Uninsured Charity Care Fees Collected: Total Paid Claims and UC Reimbursement for Reporting Period – (lines 1.12).

1.52: Equals Settlement amount: The calculation of the Medicaid and Uninsured Cost less the Minus Medicaid Payments and Uncompensated Care Fees Collected (1.5-1.51).

1.53: FMAP (Federal Medical Assistance Percentage): HHSC will enter the correct FMAP.

1.54: Federal Funds = Settlement Amount * FMAP: Will automatically calculate (1.52 multiplied by 1.53).

Cost Report Certification

DIRECTIONS TO COMPLETE Cost Report Certification.

This form attests to and certifies the accuracy of the financial information contained within the cost report. It also attests that the signer prepared the report in accordance with State and Federal audit and cost principle standards. Through this form, the signer certifies that the expenditures included in this cost report have not been claimed on any other cost report. Most of the information in the Cost Report

Certification will be updated automatically with information from previous worksheets. This form must be signed and included UPON COMPLETION OF ALL OTHER WORKSHEETS. Upon completing all the other worksheets in the cost report, please have the appropriate person read and sign the form. Scan and include the signed worksheet when sending the electronic version of the cost report to HHSC.

Signature Authority/Certifying Signature

Printed/Typed Name of Signer: Enter the name of the person that will be certifying the costs identified in the cost report.

Title of Signer: Enter the title of the signer.

Name of Provider: Enter the name of the Provider.

Address of Signer: Enter the address of the signer.

Phone Number: Enter the phone number of the signer.

Fax Number: Enter the fax number of the signer.

Email: Enter the email of the signer.

Signature of Signer and Date: The signer should sign and date the form.

Schedule A

DIRECTIONS TO COMPLETE Schedule A

Schedule A identifies allowable depreciation expenses incurred by the Provider. This worksheet will identify all depreciable assets for which there was a depreciation expense during the Cost Report period. Information on this worksheet must come from a depreciation schedule maintained by the Provider in accordance with straight-line depreciation guidelines.

Vehicles, Equipment, Building, Etc.

The straight-line method should be used for depreciation expenses.

Description of Asset: Enter the name and description of the asset. If there is the need to add additional lines, please send an email to the PFD Hospitals mailbox at pfd_hospitals@hhsc.state.tx.us.

Month/Day/Year Placed in Service: Enter the month/day/year placed in service as identified on the Provider's depreciation schedule.

Years Useful Life: Enter the number of years of useful life of the asset.

Cost: Enter the amount of the initial cost.

Prior Period Accumulated Depreciation: Enter the amount of the prior period accumulated depreciation.

Asset Disposed of in Federal Fiscal Year: Choose Y or N. Has the asset been disposed of within the Program Year?

Month/Day/Year of Disposal (If Y in Column G): Enter the date of disposal if disposal occurred within the Program Year.

Prior Period Accumulated Depreciation plus Depreciation for Reporting Period cannot exceed the total cost of an asset. In addition, assets that have been fully expensed should not be reported.

For depreciation expenses related to buildings where the Provider's vehicles or staff is housed with other agencies or entities, ONLY the Provider's portion may be reported. If this situation of shared expenses applies, the Provider must attach a supplemental worksheet showing how the Provider's portion of the building was calculated.

Worksheet B – Payroll and Benefits

DIRECTIONS TO COMPLETE Worksheet B

Worksheet B includes the salary and benefits and appropriate reductions for contract and employed staff related to the provision of dental services. Data entered on this worksheet is for an employee's salary and benefits. Salary and compensation must be reported on a direct charge basis. This worksheet includes several pre-populated staffing classifications for which information will need to be completed. These pre-populated classifications include:

Director – the salary and benefit expenditures related to developing, administration, and overall operational effectiveness of the organization. This information should include strategic planning, leadership, and oversight including, but not limited to, the Director and the Director's Assistant.

Dental Director – salary and benefit expenditures related to planning, developing, scheduling, and the implementation of dental program services and activities including, but not limited to, the Dental Director and the Dental Director's Assistant.

Dentists and Dental Assistants – salary and benefit expenditures related to dental care including, but not limited to:

- Dentists
- Dental Assistants
- Safety Officer:
- Safety Officer
- Safety Officer Assistants

Billing Account Representatives – salary and benefit expenditures related to the verification of patients' insurance coverage (including Medicaid), collection of third-party insurance submissions and payments, and patient service-related tasks including, but not limited to:

- Billing Representatives
- Account Representatives

- Patient Account Representative

Quality Assurance Technicians – salary and benefit expenditures related to analyzing performance and quality improvement program including, but not limited to Quality Assurance Technicians.

For each employee, the following information must be included:

- Employee Information
- Employee #: Enter the employee #
- Last Name: Enter the last name
- First Name: Enter the first name
- Job Title/Credentials – Enter the job title/credentials
- Employee (E)/Contractor (C) – Enter the appropriate designation, either an E or a C, for the employee.

Payroll and Benefits

Gross Salary: Enter the gross salary amount for the Reporting Period.

Total Hours Worked: Enter the total amount of hours worked in the Reporting Period.

Contractor Payments: Enter the amount of contractor payments for the employee in the Reporting Period.

Employee Benefits: Enter the amount. This amount includes all benefits that are not discretely identified in Columns J-L of this worksheet.

Employer Retirement: Enter the amount.

FICA: Enter the amount of FICA.

Medicare Payroll Taxes: Enter the amount.

Federal Funding Reductions

This worksheet section is designed to identify the federal funding or other payroll and benefit expenditure reduction necessary for the specific job classifications identified above. This worksheet section is also designed to discretely identify the payroll and benefit expenditures for any individual employee/contractor that must have a portion of their salary and/or benefits reduced from allowable expenditures on the Cost Report. For each of the job classifications identified above, the following information must be included:

Position Fully or Partially Funded by Federal Funds or Grants? Yes or No.

Enter the appropriate designation, either yes or no, for the employee for whom a portion of their salary and/or benefits must be reduced from the total allowable costs. A yes in this field designates an employee for whom federal funds or grants fund a portion or all of their salary and benefit expenditures. A no in this field

designates an employee whose salary (entire or a portion) and benefit expenditures are not funded by federal funds or grants, but whose costs still need to be removed from allowable expenditures reported on the Cost Report.

Federal Funding: If the answer to the field previously was yes, then enter the amount of federal funding related to the employee's salary and benefits that must be reduced from the total allowable costs.

Other Amounts to Be Removed: Enter the other amount to be removed from the employee's salary and benefits to be reduced from the total allowable costs.

Total Reduction: Will automatically calculate (sum of federal funding and other funds).

Worksheet C – Cost Allocation Methodologies

DIRECTIONS TO COMPLETE Worksheet C

Worksheet 7 details the cost allocation methodologies employed by the governmental entity.

A. If you entered yes on General & Statistical, Line 1.06, please provide a copy of your agency's approved Cost Allocation Plan (CAP).

B. If you entered yes on General & Statistical, Line 1.08 and 1.10, please provide a copy of your agency's approved Indirect Cost Rate (IDCR).

C. If you do not have an approved CAP or IDCR but are using another cost allocation methodology, please provide a copy of your methodology and the supporting documentation.

D. Please provide a list of personnel cost worksheets that support your CAP or IDCR.

Charity Care Template

Starting DY9, CMS changed the requirements for the Uncompensated Care program from being based on Medicaid FFS, Medicaid MCO, and uninsured costs to uninsured charity costs to comply with these updates and ensure that an adequate reporting template for the uninsured charity charges are available to support charges submitted in the cost report. Support for the submitted data must be provided and an approved charity care or financial assistance policy valid in the reporting period must be provided.

Claim/Account #: Enter the number related to the claim/account approved for charity care.

Date of Service: Enter the date the service took place. This date does not need to be within the reporting period.

Procedure Code: Enter the allowable ambulance code for the service that took place.

Charge Description: Enter the description for the procedure code.

Primary Insurance Plan: Enter the patient's insurance plan.

Secondary Insurance Plan: Enter the patient's secondary insurance plan, if applicable.

Total Charges: Enter the total amount the patient was charged.

Charity Charges: Enter the amount of the claims being covered by the Provider.

Total Payments: Enter the amount, if any, the provider paid for the service.

Write-off Date: Enter the date the charity care application was approved and accepted. Must be in the reporting period.