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

Program Training for Federal Fiscal Year (FFY) 2025 and Cost Report Training for FFY 2024

Housekeeping Items (1 of 3)

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.

Please send questions to the PHP-CCP email box at the following email address: PHP-CCP@hhs.texas.gov.

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Housekeeping Items (2 of 3)

You may ask questions throughout the presentation in the questions box. A representative will reply in the answer section or ask you to email your question to:

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Housekeeping Items (3 of 3)

You must be present and attentive throughout the entire training presentation to obtain credit. Please note:

- 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.
- The attendee must be registered for the training.
- GoToWebinar will report a poor interest rating under certain circumstances, even if you have registered and logged on. Please email us at PHP-CCP@hhs.texas.gov by the end of the day if:
  - Multiple people are viewing this training from the same device.
  - You are using a phone, tablet, dual screens, etc.

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Website & Email

You can access the Texas Health and Human Services Commission (HHSC) Provider Finance Department's Acute Care webpage by following the links below:

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

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

Send questions to the following email box: PHP-CCP@hhs.texas.gov.

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GovDelivery Updates

HHSC sends official communications via GovDelivery. Please register via the link to receive relevant and timely information from HHSC.

To create an account, go to: https://service.govdelivery.com/accounts/TXHHSC/subscriber/new.

Subscribe to the topic “Public Health Providers Charity Care Pool.”

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Texas Administrative Code (TAC) References

1 TAC Sections 355.101-107

Cost Determination Process

1 TAC Section 355.110

Informal Reviews and Formal Appeals

1 TAC Section 355.8217

Payments to Public Health Providers for Charity Care

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Year 3/FFY 2024 (Demonstration Year 13) to Year 4/FFY 2025 (Demonstration Year 14)

PHP-CCP@hhs.texas.gov

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

Year 3/FFY 2024 (DY13) to Year 4/FFY 2025 (DY14)

	Year 3 (FFY 24)	Year 4 (FFY 25)
Eligible for Reimbursement	Charity Care Only	Charity Care Only
Required Documents	Cost Report, Supporting Documentation, Charity Care Policy	Cost Report, Supporting Documentation, Charity Care Policy
Total Funding	To be determined (TBD)	TBD
Cost Report Period	October 1, 2023 – September 30, 2024	October 1, 2024 – September 30, 2025
STAIRS Cost Reports Open	Tuesday, October 1, 2024 – Thursday, November 14, 2024	Wednesday, October 1, 2025 – Friday, November 14, 2025

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What's New in FFY 2024 and FFY 2025?

- Backup documentation template (optional): Provider Name_PHP-CCP Cost Report Documentation Template and Instructions.xlsx
- Only submit updated or new Charity Care policies
- Salary ranges broadened to account for regional standards
- Descriptive text added to State of Texas Automated Information Reporting System (STAIRS).

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Overview & Participation

PHP-CCP@hhs.texas.gov

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

PHP-CCP Overview

The purpose of the new rule is to authorize HHSC to implement the PHP-CCP under the 1115 Waiver to reimburse certain costs for qualifying providers associated with providing care, including:

- Behavioral health,
- Immunizations,
- Chronic disease prevention, and
- Other preventative services for the uninsured.

This program was created as part of the 1115 Waiver extension and will provide an opportunity for reimbursement of Charity Care costs (or Medicaid shortfall in the first year of the program).

1 TAC Section 355.8215

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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, and
- Certify that no part of the PHP-CCP payment will be used to pay a contingency fee.

1 TAC Section 355.8217

Qualifying Providers

Qualifying providers must be able to certify public expenditures and will be paid an annual lump sum based on the federal match for actual expenditures.

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

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

1 TAC §355.8217

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Cost Report – Definitions

PHP-CCP@hhs.texas.gov

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

PHP-CCP Cost Report Definitions (1 of 9)

Charity Care: Healthcare services provided without expectation of reimbursement to uninsured patients who meet the provider's charity-care policy are considered charity care. The charity-care policy should adhere to the Healthcare Financial Management Association Principles and Practices Board Statement 15 (December 2019). Charity care includes full or partial discounts given to uninsured patients who meet the provider's financial assistance policy. Charity care does not include bad debt, courtesy allowances, or discounts given to patients who do not meet the provider's charity-care policy or financial assistance policy.

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PHP-CCP Cost Report Definitions (2 of 9)

Cognizant Agency: Agency responsible for reviewing, negotiating, and approving cost allocation plans or indirect cost proposals developed in accordance with the Office of Management and Budget Uniform Guidance.

Cost Allocation Plans: The means by which costs are identified in a logical and systematic manner for reimbursement under federal grants and agreements.

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PHP-CCP Cost Report Definitions (3 of 9)

Cost-to-Charge Ratio: A provider's reported costs are allocated to the Medicaid program based on a cost-to-charge ratio. The cost-to-charge ratio is calculated as the Total Allowable Cost reported for the service period to represent the numerator of the ratio to the billed charges of all claims for the service period that represents the denominator of the ratio (see below). This ratio is applied to calculate total billed charges associated with Medicaid paid claims or total computable amount for the cost report.

Cost-to-Charge Ratio =

$$\frac{\text{Total Allowable Cost Reported}}{\text{Billed Charges of All Medical Claims}}$$

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PHP-CCP Cost Report Definitions (4 of 9)

Direct Cost: This term refers to any cost explicitly associated with a particular final cost objective. Direct costs are not limited to items incorporated in the end product, such 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 Participation (FMAP) Rate: The share of state Medicaid benefit costs paid for by the federal government.

Indirect Costs: These incurred costs are identified with two or more cost objectives but are 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.

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PHP-CCP Cost Report Definitions (5 of 9)

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. Medicaid payments are made by the MCOs 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.

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PHP-CCP Cost Report Definitions (6 of 9)

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 and does not file a claim with an insurance carrier.

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PHP-CCP Cost Report Definitions (7 of 9)

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

Uncompensated Care (UC): UC is Healthcare provided for which a charge was recorded, but no payment was received. UC consists of two components:

(1) charity care, in which the patient is unable to pay,

(2) bad debt, in which payment was expected but not received.

Uncompensated care excludes other unfunded costs of care, such as underpayment from Medicaid and Medicare.

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PHP-CCP Cost Report Definitions (8 of 9)

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

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

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PHP-CCP Cost Report Definitions (9 of 9)

Unit of Government: A state, city, county, special purpose district, or other governmental unit in the State that:

- Has taxing authority with direct access to tax revenues;
- Is a State university teaching hospital with direct appropriations from the State treasury;
- 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.

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Financial Assistance Policy – Charity Care (1 of 3)

PHP-CCP@hhs.texas.gov

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

Financial Assistance Policy – Charity Care (2 of 3)

- Providers' charity care and financial assistance policies must be defined for the submitted cost reporting year and *submitted with the 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.

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Financial Assistance Policy – Charity Care (3 of 3)

A comprehensive policy (no length requirement) would include:

- Charity Care and Uninsured Related Definitions
- Effective Date (must be on or before the cost reporting period)
- Eligibility Criteria
- Eligibility Determination Methodology
- Community Communication Plan
- Regulatory Requirements
- ***List of Participating Providers***

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Charity Care and Uninsured Related Definitions

- Charity care
- Emergency medical conditions
- Family
- Family income
- Gross charges
- Medically necessary
- Underinsured
- Uninsured

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Effective Date

The Financial Assistance Policy must include the policy's effective date.

The date must be on or before the first day of the cost reporting period. For example, on or before October 1, 2024, for FFY 2025.

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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 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.

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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 Healthcare Financial Management Association (HFMA) Patient Friendly Billing Project and Patient Financial Communication Best Practices to ensure their financial communications are:

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

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Best Practices for Financial Communications

- Focus on compassion
- Define policies
- Hold annual staff training
- Conduct patient conflict resolution via face-to-face discussions with registration or discharge staff
- Offer patient support

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Best Practices for Financial Communications (continued)

- 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

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.

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List of Participating Providers

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

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Cost Report – Overview (1 of 3)

PHP-CCP@hhs.texas.gov

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

Cost Report – Overview (2 of 3)

A provider must prepare and complete a PHP-CCP Cost Report annually.

- The provider must submit the cost report to HHSC.
- The cost report period begins on October 1 and ends on September 30 of the following year.
- Cost reports are open for submission immediately after the end of the cost report period (October 1) and are due within 45 days (November 14).

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Cost Report – Overview (3 of 3)

FFY/DY	Report Service Period	Report Due Date
FFY 2024/DY13	10/01/2023 – 09/30/2024	11/14/2024
FFY 2025/DY14	10/01/2024 – 09/30/2025	11/14/2025

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

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Cost Report Training Requirements

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

- A PHP-CCP financial contact (employee of the provider) must attend training for each program period.
- Multiple individuals from a qualifying provider may attend.
- Training is provided for each program period and is offered just before the beginning of the program year.
- 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.

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Cost Report – Overview

Cost Report Preparation & Certification

- An eligible and participating provider will prepare the cost report.
- Only costs for charity care services delivered in the program year (date of service from October 1 to September 30) and not reimbursed by another source are eligible for reimbursement.

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.

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Cost Report Walkthrough

STAIRS Steps 1 and 2 – Entity Data

Entity Identification: Enter information for the Entity's phone, fax, and physical and mailing address(es); Contact name, email, phone, and address; Financial Contact name, email, phone, and address; Report Preparer name, email, phone, and address; and Location of Accounting Records that Support this Report.

General Information: Verify the actual **Reporting Period** for which the cost report will be completed.
(For example, 10/01/10 to 09/30/11).

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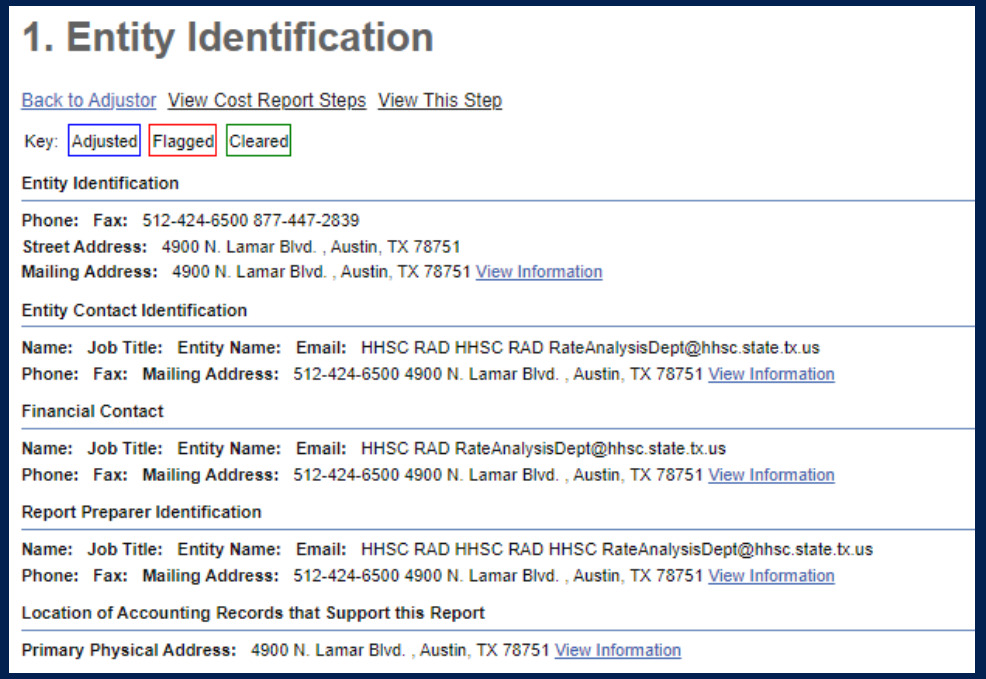
Entity Identification and General Information

Entity Identification



1. Entity Identification

Back to Adjustor View Cost Report Steps View This Step

Key: Adjusted Flagged Cleared

Entity Identification

Phone: **Fax:** 512-424-6500 877-447-2839
Street Address: 4900 N. Lamar Blvd. , Austin, TX 78751
Mailing Address: 4900 N. Lamar Blvd. , Austin, TX 78751 View Information

Entity Contact Identification

Name: **Job Title:** **Entity Name:** **Email:** HHSC RAD HHSC RAD RateAnalysisDept@hhsc.state.tx.us
Phone: **Fax:** **Mailing Address:** 512-424-6500 4900 N. Lamar Blvd. , Austin, TX 78751 View Information

Financial Contact

Name: **Job Title:** **Entity Name:** **Email:** HHSC RAD RateAnalysisDept@hhsc.state.tx.us
Phone: **Fax:** **Mailing Address:** 512-424-6500 4900 N. Lamar Blvd. , Austin, TX 78751 View Information

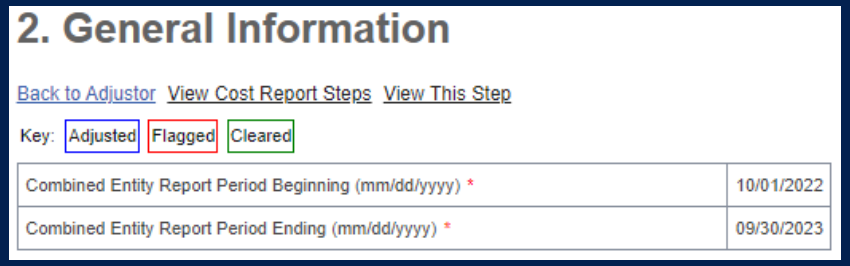
Report Preparer Identification

Name: **Job Title:** **Entity Name:** **Email:** HHSC RAD HHSC RAD HHSC RateAnalysisDept@hhsc.state.tx.us
Phone: **Fax:** **Mailing Address:** 512-424-6500 4900 N. Lamar Blvd. , Austin, TX 78751 View Information

Location of Accounting Records that Support this Report

Primary Physical Address: 4900 N. Lamar Blvd. , Austin, TX 78751 View Information

General Information



2. General Information

Back to Adjustor View Cost Report Steps View This Step

Key: Adjusted Flagged Cleared

Combined Entity Report Period Beginning (mm/dd/yyyy) *	10/01/2022
Combined Entity Report Period Ending (mm/dd/yyyy) *	09/30/2023

STAIRS Step 3 – Contract Management

3.a. Verify Contracts for Requested Reports: Verify the primary contract associated with the PHP-CCP cost report.

3.b. Enter Other Business Components (Other Contracts, Grants or Business Relationships with the State of Texas or any other entity, or other funding sources)

3.c. Verify Business Component Summary

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STAIRS Step 4 – General Information (1 of 3)

Primary National Provider Identification Number (NPI): Verify the main **10-digit NPI** number for the provider completing the cost report. (For example, 1234567890).

Reporting Period: Enter the actual **Reporting Period** for which the cost report will be completed. (For example, 10/01/10 to 09/30/11.)

Associated Texas Provider Identification Numbers (TPI): Enter the other associated **9-digit TPI** numbers for the provider completing the cost report. (For example, 123456789, 987654321, 012345678, etc.)

Associated National Provider Identification Numbers (NPI): Enter the other associated **10-digit NPI** numbers for the provider completing the cost report. (For example, 1234567890, 0123456789, 1231231230, etc.)

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STAIRS Step 4 – General Information (2 of 3)

Did the preparer(s) of this report review the most recently received Provider Adjustment Report and make the necessary revisions when preparing this report?: Select Yes or No.

Does the agency have an approved Cost Allocation Plan (CAP)?: Please provide the name of the Cognizant Agency who approved the CAP and upload a copy of the agency proposed Cost Allocation Plan.

Please provide a list of personnel cost worksheets that support your CAP, otherwise attach in detail the allocation methodology that will be used for allocating costs on the cost report.

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STAIRS Step 4 – General Information (3 of 3)

Has a current Charity Care Policy been uploaded with a PHP-CCP cost report in a previous year?: Indicate response in the checkbox.

If a current Charity Care Policy has not been submitted to PHP-CCP, or your policy has changed, please upload your most recent policy.

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STAIRS Step 5 - General and Statistical (1 of 4)

Charity Reimbursements: The reimbursements entered must be only for dates of service during the cost report period and must exclude all unfunded Medicaid and Medicare costs.

Total Billed Charges Associated with Charity Care: The **Total Billed Charges** entered must be only for dates of service during the cost report period. Billed charges are based on the local chargemaster that sets the usual and customary rate for services.

Total Uninsured Billed Charges (excluding Charity Care): Enter the **Total Uninsured Billed Charges Associated (excluding Charity Care)** for the applicable cost report period identified on the form. The total billed charges entered must be only for dates of service during the cost report period. Billed charges are based on the local chargemaster that sets the usual and customary rate for services.

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Step 5 - (2 of 4)

Total Billed Charges Associated with Medicaid FFS Paid Claims: Enter the **Total Billed Charges associated with Medicaid FFS Paid Claims** for the applicable cost report period identified on the form. The total billed charges associated with Medicaid FFS paid claims must be entered only for dates of service during the cost report period. Billed charges are based on the local chargemaster that sets the usual and customary rate for services.

Total Billed Charges Associated with MCO Paid Claims: Enter the **Total Billed Charges associated with Medicaid MCO Paid Claims** for the applicable cost report period identified on the form. The total billed charges associated with MCO paid claims must be entered only for dates of service during the cost report period. Billed charges are based on the local chargemaster that sets the usual and customary rate for services.

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Step 5 – (3 of 4)

Medicare Costs: Enter the total **Medicare Costs** for services provided for the applicable cost report period identified on the form. The Medicare costs for services entered should be for dates of service during the cost report period.

Other Third-Party Insurance Coverage: Enter the total **Other Third-party Coverage Commercial Pay** Costs for services provided for the applicable cost report period identified on the form. The "other" costs for services entered should be for dates of service during the cost report period.

Self-Pay, County/City Indigent Recipient Program Costs: Enter the total **Self-pay, or County/City Indigent Costs** for services provided for the applicable cost report period identified on the form. The "other" costs for services entered should be for dates of service during the cost report period.

Total Charges (All Sources): The **Total Charges (All Sources)** is calculated by combining all the different charge amounts for the applicable cost report period identified on the form.

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Step 5 – (4 of 4)

Total Charity Care Encounters: Enter the **Total Charity Care Encounters** for the dates of service during the cost report period.

Medicaid Clients Served: Enter the number of **Medicaid clients served** for the dates of service during the cost report period.

All Clients Served (Medical + Non-Medical): Enter the **total number of all clients served** for the dates of service during the cost report period.

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STAIRS Step 5 – General and Statistical

5. General & Statistical

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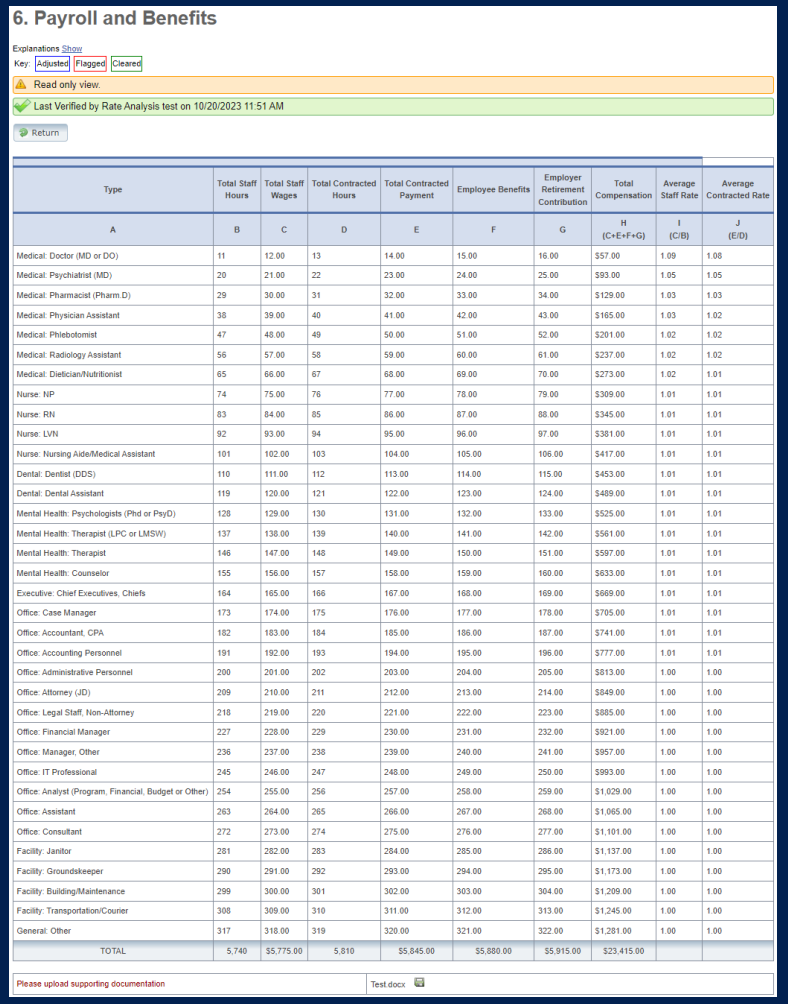
Return

For use in calculating reimbursements for charity care costs. Please report charges and payments received for patients treated under your facility's Charity Care Policy.

Charity Reimbursements	$1,000
Total Billed Charges Associated with Charity Care	$1,000
Total Uninsured Billed Charges (excluding Charity Care)	$1,000
Total Billed Charges Associated With Medicaid FFS Paid Claims	$1,000
Total Billed Charges Associated With MCO Paid Claims	$1,000
Medicare Charges	$1,000
Other Third-Party Insurance Coverage Charges	$1,000
Self Pay, County/City Indigent Recipient Program Charges	$1,000
Total Charges (All Source)	7,000
Total Charity Care Encounters	5
Medical Clients Served	3
All Clients Served (Medical + Non-Medical)	10
Please provide supporting documentation.	111114-2023-test.txt

STAIRS Step 6 – Payroll and Benefits

This step in STAIRS includes all personnel-related expenditures and hours for the job classifications identified. Enter the necessary quantified data into each section and upload supporting documentation.



6. Payroll and Benefits

Explanations Show

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Return

Type	Total Staff Hours	Total Staff Wages	Total Contracted Hours	Total Contracted Payment	Employee Benefits	Employer Retirement Contribution	Total Compensation	Average Staff Rate	Average Contracted Rate
A	B	C	D	E	F	G	H (C+E+F+G)	I (C/B)	J (E/D)
Medical: Doctor (MD or DO)	11	12.00	13	14.00	15.00	16.00	$57.00	1.09	1.08
Medical: Psychiatrist (MD)	20	21.00	22	23.00	24.00	25.00	$93.00	1.05	1.05
Medical: Pharmacist (Pharm.D)	29	30.00	31	32.00	33.00	34.00	$129.00	1.03	1.03
Medical: Physician Assistant	38	39.00	40	41.00	42.00	43.00	$165.00	1.03	1.02
Medical: Phlebotomist	47	48.00	49	50.00	51.00	52.00	$201.00	1.02	1.02
Medical: Radiology Assistant	56	57.00	58	59.00	60.00	61.00	$237.00	1.02	1.02
Medical: Dietician/Nutritionist	65	66.00	67	68.00	69.00	70.00	$273.00	1.02	1.01
Nurse: NP	74	75.00	76	77.00	78.00	79.00	$309.00	1.01	1.01
Nurse: RN	83	84.00	85	86.00	87.00	88.00	$345.00	1.01	1.01
Nurse: LVN	92	93.00	94	95.00	96.00	97.00	$381.00	1.01	1.01
Nurse: Nursing Aide/Medical Assistant	101	102.00	103	104.00	105.00	106.00	$417.00	1.01	1.01
Dental: Dentist (DDS)	110	111.00	112	113.00	114.00	115.00	$453.00	1.01	1.01
Dental: Dental Assistant	119	120.00	121	122.00	123.00	124.00	$489.00	1.01	1.01
Mental Health: Psychologists (Phd or PsyD)	128	129.00	130	131.00	132.00	133.00	$525.00	1.01	1.01
Mental Health: Therapist (LPC or LMSW)	137	138.00	139	140.00	141.00	142.00	$561.00	1.01	1.01
Mental Health: Therapist	146	147.00	148	149.00	150.00	151.00	$597.00	1.01	1.01
Mental Health: Counselor	155	156.00	157	158.00	159.00	160.00	$633.00	1.01	1.01
Executive: Chief Executives, Chiefs	164	165.00	166	167.00	168.00	169.00	$669.00	1.01	1.01
Office: Case Manager	173	174.00	175	176.00	177.00	178.00	$705.00	1.01	1.01
Office: Accountant, CPA	182	183.00	184	185.00	186.00	187.00	$741.00	1.01	1.01
Office: Accounting Personnel	191	192.00	193	194.00	195.00	196.00	$777.00	1.01	1.01
Office: Administrative Personnel	200	201.00	202	203.00	204.00	205.00	$813.00	1.00	1.00
Office: Attorney (JD)	209	210.00	211	212.00	213.00	214.00	$849.00	1.00	1.00
Office: Legal Staff, Non-Attorney	218	219.00	220	221.00	222.00	223.00	$885.00	1.00	1.00
Office: Financial Manager	227	228.00	229	230.00	231.00	232.00	$921.00	1.00	1.00
Office: Manager, Other	236	237.00	238	239.00	240.00	241.00	$957.00	1.00	1.00
Office: IT Professional	245	246.00	247	248.00	249.00	250.00	$993.00	1.00	1.00
Office: Analyst (Program, Financial, Budget or Other)	254	255.00	256	257.00	258.00	259.00	$1,029.00	1.00	1.00
Office: Assistant	263	264.00	265	266.00	267.00	268.00	$1,065.00	1.00	1.00
Office: Consultant	272	273.00	274	275.00	276.00	277.00	$1,101.00	1.00	1.00
Facility: Janitor	281	282.00	283	284.00	285.00	286.00	$1,137.00	1.00	1.00
Facility: Groundskeeper	290	291.00	292	293.00	294.00	295.00	$1,173.00	1.00	1.00
Facility: Building/Maintenance	299	300.00	301	302.00	303.00	304.00	$1,209.00	1.00	1.00
Facility: Transportation/Courier	308	309.00	310	311.00	312.00	313.00	$1,245.00	1.00	1.00
General: Other	317	318.00	319	320.00	321.00	322.00	$1,281.00	1.00	1.00
TOTAL	5,740	$5,775.00	5,810	$5,845.00	$5,880.00	$5,915.00	$23,415.00		

Please upload supporting documentation

Test.docx

STAIRS Step 7 -Payroll Taxes and Federal Funding Reductions

Employer FICA and other Payroll taxes, Unemployment Taxes and Compensation, and Federal and Other Funding Reductions (e.g., Grants, Donations, Appropriations) will be entered under Step 7.

7. Payroll Taxes and Federal Funding Reductions

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Return

Payroll Taxes					
Position Type	Employer FICA Payroll Taxes	Employer Other Payroll Taxes	State Unemployment Payroll Taxes	Federal Unemployment Payroll Taxes	Unemployment Compensation (Reimbursing Employer)
Medical: Doctor (MD or DO)	11.00	12.00	13.00	14.00	15.00
Medical: Psychiatrist (MD)	16.00	17.00	18.00	19.00	20.00
Medical: Pharmacist (Pharm.D)	21.00	22.00	23.00	24.00	25.00
Medical: Physician Assistant	26.00	27.00	28.00	29.00	30.00
Medical: Phlebotomist	31.00	32.00	33.00	34.00	35.00
Medical: Radiology Assistant	36.00	37.00	38.00	39.00	40.00
Medical: Dietician/Nutritionist	41.00	42.00	43.00	44.00	45.00
Nurse: NP	46.00	47.00	48.00	49.00	50.00
Nurse: RN	51.00	52.00	53.00	54.00	55.00
Nurse: LVN	56.00	57.00	58.00	59.00	60.00

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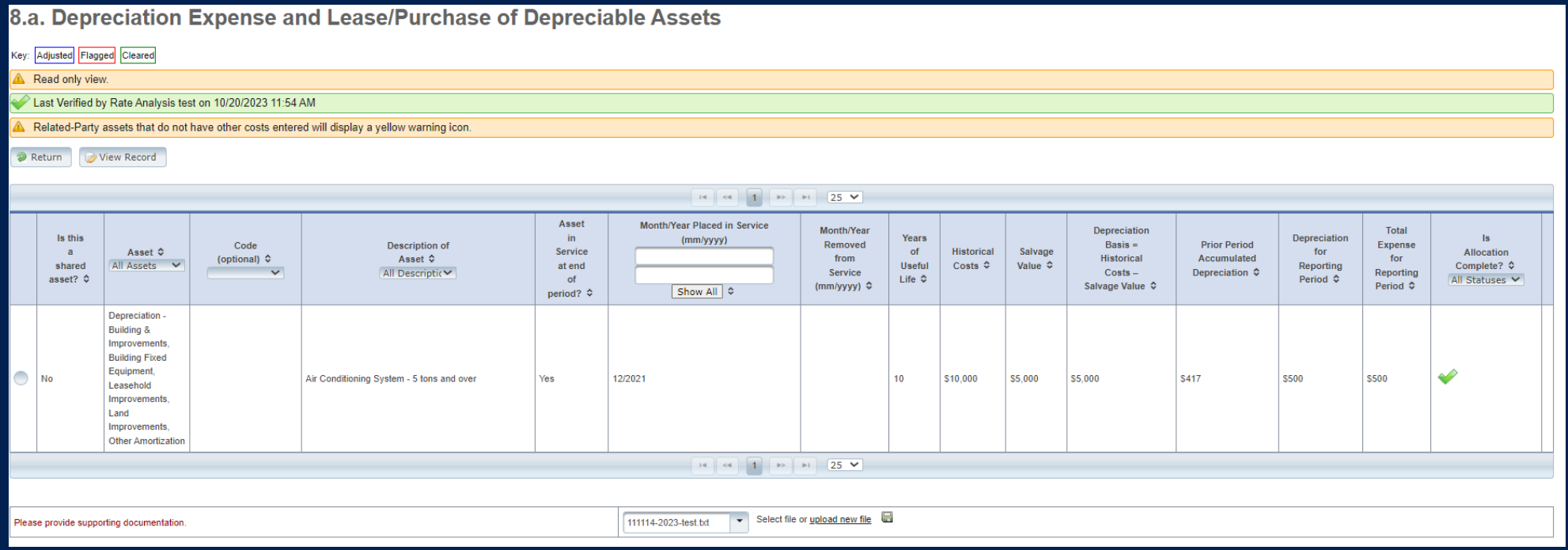
STAIRS Step 7 -Payroll Taxes and Federal Funding Reductions (continued)

This section is designed to discretely identify the 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.

Federal Funding and Other Reductions			
Position Type	Other Federal Funds and Grants/Donations/Appropriations	Other Reductions	Total
Medical: Doctor (MD or DO)	191.00	192.00	$383
Medical: Psychiatrist (MD)	194.00	195.00	$389
Medical: Pharmacist (Pharm.D)	197.00	198.00	$395
Medical: Physician Assistant	200.00	201.00	$401
Medical: Phlebotomist	203.00	204.00	$407
Medical: Radiology Assistant	206.00	207.00	$413
Medical: Dietician/Nutritionist	209.00	210.00	$419
Nurse: NP	212.00	213.00	$425
Nurse: RN	215.00	216.00	$431
Nurse: LVN	218.00	219.00	$437

Do you have other non-payroll reductions to report that are not listed above?	$297
Please report any non-payroll reductions here:	Note: test

STAIRS Step 8.a – Depreciation Expense & Purchase of Depreciable Assets



8.a. Depreciation Expense and Lease/Purchase of Depreciable Assets

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Related-Party assets that do not have other costs entered will display a yellow warning icon.

Return View Record

	Is this a shared asset?	Asset (All Assets)	Code (optional)	Description of Asset (All Descriptic)	Asset in Service at end of period?	Month/Year Placed in Service (mm/yyyy) (Show All)	Month/Year Removed from Service (mm/yyyy)	Years of Useful Life	Historical Costs	Salvage Value	Depreciation Basis = Historical Costs – Salvage Value	Prior Period Accumulated Depreciation	Depreciation for Reporting Period	Total Expense for Reporting Period	Is Allocation Complete? (All Statuses)
	No	Depreciation - Building & Improvements, Building Fixed Equipment, Leasehold Improvements, Land Improvements, Other Amortization		Air Conditioning System - 5 tons and over	Yes	12/2021		10	$10,000	$5,000	$5,000	$417	$500	$500	✓

Please provide supporting documentation. 111114-2023-test.txt Select file or upload new file

Depreciation (1 of 3)

The purpose of depreciation is to apply the expense portion of an asset that relates to the revenue generated by the asset. Depreciation and use allowances are means of allocating the cost of fixed assets to periods benefiting from asset use.

Depreciation is the periodic reduction of the value of an asset over its useful life or the recovery of an asset's cost over its useful life.

Amortization is the periodic reduction of the value of an intangible asset's value, such as a trademark or patent, or debt over its useful life.

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Depreciation (2 of 3)

The computation of depreciation or use allowances to ensure its classification and estimated useful life is accurate if based on the following:

- Allowable cost specific to the PHP-CCP program
- Historical cost
- Date of purchase
- Depreciable basis
- Use of values consistent with "Estimated Useful Lives of Depreciable Hospital Assets," published by the American Hospital Association

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Depreciation (3 of 3)

The following must be accessible in a field audit for each depreciable asset:

- Estimated useful life
- Accumulated depreciation
- Calculation of gains and losses upon disposal

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Depreciation – Vehicles

Depreciation of vehicles is limited to only the vehicles used in the delivery, transportation, or both of recipients to and from a Title XIX medical service. No other vehicles are to be included in the costing or depreciation application for this pool payment.

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Depreciation – Building

For depreciation expenses related to buildings where the provider's vehicles or staff are housed with other agencies or entities, **ONLY the portion related to the provider** may be reported, and the provider must follow Medicare depreciation instructions. The provider must attach a supplemental exhibit showing how the portion of the building related to the provider was calculated.

A building's life must be reported as consistent with the most recent revision of the American Hospital Association's Estimated Useful Lives of Depreciable Hospital Assets.

The depreciation computation or use allowances will exclude:

- The cost of land, and
- Any portion of the cost of a building donated by the Federal Government.

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Depreciation – Building (continued)

A building's shell may be segregated from the major components of the building (for example, the plumbing, heating, and air conditioning systems, etc.), and each major component depreciated over its estimated useful life.

Or

The entire building (for example, the shell and all components) may be treated as a single asset and depreciated over a single useful life.

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Depreciation

Asset Description: The name or account code, or both, will suffice. Please add additional lines if needed.

Month/Year Placed in Service: The month and the year that the depreciable asset was first put into service.

Month/Year of Disposal: The month and the year that the depreciable asset was removed from service.

Years Useful Life: Enter the numeric value as identified on the provider's depreciation schedule. (For example, enter 20 for twenty years of useful life.)

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Depreciation (continued)

Historical Costs: Enter the asset's **costs** as identified on the provider's depreciation schedule.

Salvage Value: Enter the value of the asset after depreciation has been fully expensed.

Prior Period Accumulated Depreciation: Enter the amount related to the asset as identified on the provider's depreciation schedule. This number is the total amount of depreciable expenses to date related to the depreciable asset.

Depreciation for Reporting Period: This number is the total amount of depreciable expense incurred during the Cost Report period.

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Depreciate or Expense?

Follow this guide to help determine whether to expense or depreciate a purchased item:

- **Cost < $5,000 or 1 Year Useful Life** – Expense any single item costing less than $5,000 or having a useful life of one year or less.
- **Cost ≥ $5,000 and 1 Year Useful Life** – An asset valued at $5,000 or more and with an estimated useful life of more than one year at the time of purchase must be depreciated or amortized using the straight-line method.
- **Cost < $5,000 and Useful Life is greater than a year** – The provider has an option to either expense or depreciate the purchased item, but the reporting must be consistent each reporting period.

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STAIRS Step 8.b – Facility, Operations, and Other Costs

This section identifies other operating costs not related to the job classifications identified in Step 6. Within this section, Support Services or Other may include personnel-related expenditures not identified in the job classifications in Step 6.

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STAIRS Step 8.b – Facility, Operations, and Other Costs (continued)

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8.b. Facility, Operations, and Other Costs

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Type	Expense	Notes (optional)
Supplies & Materials Non-Medical	2,000	
Supplies & Materials Medical	2,000	
Equipment Non-Medical	2,000	
Equipment Medical	2,000	
Support Services (IT, Dispatch, Call Handling, etc...)	2,000	
Other Costs	2,000	
Depreciation (Total from Step 8a)	$0	
Total Direct Medical / Other Costs	**$12,000**	

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STAIRS Step 9 – Preparer Verification

Step 9 summarizes all service costs listed throughout other steps in the Cost Report.

Only allocable expenditures related to Charity Care as defined and approved in the Texas Healthcare Transformation and Quality Improvement 1115 Waiver Program will be included for supplemental payment.

This step sums the personnel expenses and adds additional costs to calculate the total cost of Charity Care Services.

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STAIRS Step 10 – Report Certifications

Cost Report Certification: Certification is required and formally acknowledges that the cost report is true, correct, complete, and was prepared in accordance with all rules and regulations.

- Must be completed and signed by an individual legally responsible for the conduct of the provider, such as the authorized agent.
- The responsible party must have PHP-CCP training credits for the corresponding reporting period.
- *The responsible party's signature must be notarized*.

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STAIRS Step 11 – Report Certifications

Claimed Expenditures: Certifies that expenditures are allocable and allowable to the State Medicaid program under Title XIX of the Social Security Act and in accordance with all procedures, instructions, and guidance issued by the single state agency and in effect during the cost report year.

- Government Provider Name, Total Computable amount, and reporting period dates are auto-populated.
- Must be completed & signed by an individual legally responsible for the conduct of the provider, such as the authorized agent.
- The responsible party should read the certification statements carefully before signing the form before a notary.
- *The responsible party's signature must be notarized.*

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Break Time!

Be back in 10 minutes.

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PHP-CCP@hhs.texas.gov

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

Fairbanks Demonstration

Fairbanks, LLC website: Fairbanks LLC
Cost Report Login: Fairbanks LLC CR - Login

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PHP-CCP@hhs.texas.gov

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

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Submission, Reviews, & Appeals

PHP-CCP@hhs.texas.gov

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

Cost Report Submission/Review Process

- Submitted cost reports are logged and tracked by HHSC.
- HHSC submits a SAR (State-Action Request) to TMHP to receive all prudent claims data pertaining to each provider for the corresponding reporting period.
- HHSC conducts a desk review, also known as a field audit.
  - Reviews each cost report on an individual basis

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Cost Report Submission/Review Process (continued)

- HHSC conducts a desk review on each cost report.
- HHSC completes reviews within approximately 60 days of cost report submission.
- Informal reviews of specific items may be requested.
- Formal appeals may be requested after an Informal Review.

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Desk Reviews

Providers are responsible for responding to HHSC Provider Finance staff within 5 business days from the date HHSC requests clarification, additional information, or both. On a second review, this turnaround time may be reduced to 2 business days.

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Desk Reviews (continued)

- The template for backup documentation can be downloaded from our website. It is designed to streamline the submission and review process and allow an expedited payment timeline.
- You may submit your own documentation.
  - Excel files are strongly preferred.
  - Please ensure that calculations are included, cells with totals are highlighted and match the STAIRS entry.
  - Please ensure the job titles match the STAIRS categories.
  - Assets or expenses not entered in STAIRS should not be included on your backup documentation.

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Common Desk Review Findings

- Documentation does not support services rendered.
- Documentation includes service dates outside of the reporting period.
- Documentation does not support costs reported on the cost report.
- Providers include unallowable claims in FFS and MCO charges and payments.
- Charity Care policy is missing the provider list.
- Depreciable assets are missing.

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Desk Reviews and Field Audits

Providers are responsible to respond to HHSC Provider Finance staff within 5 business days from the date HHSC requests clarification and/or additional information.

Records must be accessible to HHSC Audit staff upon request. When records are not in Texas, the provider must pay the costs for HHSC staff to travel and review records out of state.

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Desk Reviews and Field Audits (continued)

HHSC emails notices stating that the exclusions and adjustments reports for providers are available. These reports identify:

- Items that have been adjusted
- The amount of each adjustment
- The reason for each adjustment

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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.
- Review will only be conducted on items specified in the Informal Review Request. A full cost report review will not be conducted.

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TAC Section 355.110

Appeal Process

If a provider does not agree with the decision made by HHSC PFD, the entity has an option to file an appeal through the HHSC appeal process. The formal appeal is limited to the issues considered in the informal review process.

Formal appeals are conducted in accordance with Title 1 Texas Administrative Code Section 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

TAC Section 355.110

Medicaid Records Retention Policy

State laws generally govern how long medical records must be retained. However, the Health Insurance Portability and Accountability Act (HIPAA) 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. HIPAA policies and procedures and documentation requirements can be found at 45 CFR 164.316(b)(2)(i)-(iii).

The Centers for Medicare and 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).

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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

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Reminder: GovDelivery Updates

HHSC sends official communications via GovDelivery. Please register via the link to receive relevant and timely information from HHSC.

To create an account, go to: https://service.govdelivery.com/accounts/TXHHSC/subscriber/new.

Subscribe to the topic “Public Health Providers Charity Care Pool.”

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Closing Remarks

PHP-CCP@hhs.texas.gov

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