HHSC Rate Analysis
Disproportionate Share Hospital (DSH), Uncompensated Care (UC), Delivery System Reform Incentive Payment (DSRIP), and Indigent Care Program Expenditures Survey

The 2014-2015 General Appropriations Act (Article II, Health and Human Services Commission, Rider 43, S.B. 1, 83rd Legislature, Regular Session, 2013) requires the Health and Human Services Commission (HHSC) to collect information from selected providers on their expenditures related to the Disproportionate Share Hospital (DSH), Uncompensated Care (UC), Delivery System Reform Incentive Payment (DSRIP), and Indigent Care programs during federal fiscal year 2015 (October 1, 2014 thru September 30, 2015). This survey will gather the information from providers participating in those programs. The Health and Human Services Commission will compile and submit to the Texas Legislature a report detailing each provider's individual response. If a provider does not complete the survey they will be listed in the report as non-responsive.

The Expenditures Survey was conducted previously under Rider 43 of the 2014-2015 General Appropriations Act (Article II, Health and Human Services Commission, Rider 43, S.B. 1, 83rd Legislature, Regular Session, 2013). The results from this yearly survey can be found on the HHSC website under the Rate Analysis for Hospital Services section.

All providers who received these funds are required to complete this survey. The survey must be completed no later than 5:00 p.m., October 28, 2016.

For questions regarding the content of the survey, please contact the UC Tools mailbox via email: uctools@hhsc.state.tx.us or via phone: (512) 487-3480.

For technical questions regarding the survey website, please contact the Rate Analysis Help Desk at (512) 490-3193.

SECTION 1. PROVIDER INFORMATION

Provider TPI Number:

Provider Name:

Provider Street Address (street, PO Box):

City: **State:** **Zip:**

☐ Check this box if Street Address and Mailing Address are the same.

Provider Mailing Address (street, PO Box):

City: **State:** **Zip:**

Provider Telephone:
example: 512-438-5555

Provider Fax Number:
example: 512-438-5555

Officer, Partner, or Administrator Name:

Officer, Partner,or Administrator Email:

Officer, Partner,or Administrator Phone:

REPORT PREPARER INFORMATION

Preparer Name:

Preparer Title:

Preparer Email:
example: Joe.Smith@hosp.com

Preparer Business Name:

Preparer Street Address (street, P.O. Box):

City: **State:** **Zip:**

☐ Check this box if Street Address and Mailing Address are the same.

Preparer Mailing Address (street, P.O. Box):

City: **State:** **Zip:**

Preparer Telephone:
example: 512-438-5555

Preparer Fax Number:
example: 512-438-5555

PROVIDER PROGRAM

Provider Type:

- ○ Public Hospital (non-state)
- ○ Private Hospital
- ○ Hospital District
- ○ Physician/Physician Group

- ○ Other

Funds received for federal fiscal year 2015 by program:

Indicate which program(s) and the All Funds amount of payments received attibutable to federal fiscal year 2015 (October 1, 2014 to September 30, 2015).

Disproportionate Share Hospital (DSH)		(If none leave blank, do not fill section 2)
Uncompensated Care (UC)		(If none leave blank, do not fill section 3)
Delivery System Reform Incentive Payment (DSRIP)		(If none leave blank, do not fill section 4)
Indigent Care		(If none leave blank, do not fill section 5)

If you did not receive any revenues from these programs for federal fiscal year 2015, click the submit button below.

SECTION 2. DSH PROGRAM

The DSH program provides supplemental payments to providers that serve a disproportionate amount of Medicaid and uninsured patients. Providers that meet certain utilization criteria submit an application to the program and may be provided a payment for the costs of providing care for the uninsured and for Medicaid costs that were not previously compensated.

For DSH payments received for federal fiscal year 2015, indicate what activities these revenues supported. The services listed below are illustrative. Please use the "Other" category as necessary, with a brief description detailing the nature of the expenditures being reported. The total should equal the amount of the DSH payments received and reported in section 1.

DSH Payments Received

Services and Functions	**Amount in Dollars**
Capital Improvements	
Outpatient Services	
Inpatient Services	
Clinics	
Physician Services	
Prescription Drugs	
Other (please specify)	
Other (please specify)	
Other (please specify)	

DSH Section Total Amt

SECTION 3. UC PROGRAM

The UC program provides supplemental payments to providers that serve individuals who have no third party coverage for the services provided by hospitals or other providers. Providers that meet certain utilization criteria submit an application to the program and may be provided a payment for the cost of providing care for Medicaid and uninsured patients, for which the provider does not receive payment.

For UC payments received for federal fiscal year 2015, indicate what activities these revenues supported. The services listed below are illustrative. Please use the "Other" category as necessary, with a brief description detailing the nature of the expenditures being reported. The total should equal the amount of the UC payments received and reported in section 1.

UC Payments Received

Services and Functions	**Amount in Dollars**
Total Expenditures	
Other (please specify)	
Other (please specify)	
UC Section Total Amt	

SECTION 4. DSRIP PROGRAM

The DSRIP program provides supplemental payments that support coordinated care and quality improvements through Regional Healthcare Partnerships (RHP) to transform care delivery systems. Providers that meet certain criteria submit an application to the program and may be provided a payment for achieving certain goals that are intended to improve the quality and lower the cost of care.

For DSRIP payments received for federal fiscal year 2015, indicate what activities these revenues supported. This question is not asking for the cost of the DSRIP project; rather it is requesting general information on how DSRIP funds were used. The activities below are illustrative. Please use the “Other” category as necessary, with a brief description detailing the nature of the expenditures being reported. The total should equal the amount of the DSRIP payments received and reported in section 1.

DSRIP Payments Received

Services and Functions	**Amount in Dollars**
Outpatient Services	
Inpatient Services	
Clinics	
Physician Services	
Education	
Outreach	
Case Management	
Behavioral Health	
Information Technology	
Health Care Technology	
Other (please specify)	

Other (please specify)

DSRIP Section Total Amt

SECTION 5. INDIGENT CARE PROGRAM

The Indigent Care program provides supplemental payments to providers that provide health care services to eligible residents through the counties, hospital districts, and public hospitals in Texas. Providers that meet certain utilization criteria submit an application to the program and may be provided a payment for the costs of providing care for Texas residents who do not qualify for other state or federal health care assistance programs.

For Indigent Care payments received for federal fiscal year 2015, indicate what activities these revenues supported. The services listed below are illustrative. Please use the "Other" category as necessary, with a brief description detailing the nature of the expenditures being reported. The total should equal the amount of the Indigent Care payments received and reported in section 1.

Indigent Care Payments Received

Services and Functions	**Amount in Dollars**
Total Expenditures	
Other (please specify)	
Other (please specify)	

Indigent Care Section Total Amt

SECTION 6. REVENUE MAXIMIZATION SERVICES (required for hospital providers)

During federal fiscal year 2015 (October 1, 2014 to September 30, 2015), did you make any payments to entities that provide consultative services for revenue maximization?

Revenue Maximization Services represent any consultative or legal support services in which the entity provided support or development of strategies and tactics meant to improve profitability.

- Yes
- No

If you answered "yes", please supply any additional information in the text field below that you believe is necessary to accurately describe such Revenue Maximization Services. Complete the chart that follows for each government funded program(s) that were reviewed for revenue maximization.

1000 characters remaining

Please check all that apply:

- Medicaid (Medical Assistance Program)
- DSH
- UC
- DSRIP
- Other Government Funded Program

Medicaid

Entity Providing Revenue Maximization Services:

Entity Name:

Contact Person Name:

Contact Person Email:
example: Joe.Smith@hosp.com

Contact Person Phone Number:
example: 512-438-5555

Aggregate amount of payments made to entity:

Purpose of payment:

Source of funding for payments:

Disproportionate Share Hospital

Entity Providing Revenue Maximization Services:

Entity Name:

Contact Person Name:

Contact Person Email:
example: Joe.Smith@hosp.com

Contact Person Phone Number:
example: 512-438-5555

Aggregate amount of payments made to entity:

Purpose of payment:

Source of funding for payments:

Uncompensated Care

Entity Providing Revenue Maximization Services:

Entity Name:

Contact Person Name:

Contact Person Email:
example: Joe.Smith@hosp.com

Contact Person Phone Number:
example: 512-438-5555

Aggregate amount of payments made to entity:

Purpose of payment:

Source of funding for payments:

Delivery System Reform Incentive Payment

Entity Providing Revenue Maximization Services:

Entity Name:

Contact Person Name:

Contact Person Email:
example: Joe.Smith@hosp.com

Contact Person Phone Number:
example: 512-438-5555

Aggregate amount of payments made to entity:

Purpose of payment:

Source of funding for payments:

Other Government Funded Program

Entity Providing Revenue Maximization Services:

Entity Name:

Contact Person Name:

Contact Person Email:
example: Joe.Smith@hosp.com

Contact Person Phone Number:
example: 512-438-5555

Aggregate amount of payments made to entity:

Purpose of payment:

Source of funding for payments:

REPORT CERTIFICATION

☐ I attest that I have examined the information contained in this survey, prepared for the above named provider and for the period as stated above. To the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions. After submission of this document, if I become aware of additional information that is relevant to this survey, I will notify HHSC and resubmit data if necessary.

Name of Person completing this survey: