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

Cost Report Training for Federal Fiscal Year 2022

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Short breaks will be provided.

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PHP-CCP@hhs.texas.gov

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This will help us ensure that you receive credit for attending today.

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Website & Email

You can access the 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 and it will take you directly to the webpage.

Send Cost Report Questions/Cost Report Submissions to the following email box:

PHP-CCP@hhs.texas.gov

Overview & Participation

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).

TEXAS Health and Human Services

TAC §355.8215

PHP-CCP Rules

The PHP-CCP rules for Year 1 are located at Title 1 Texas Administrative Code (TAC) Section 355.8215. Rule 8215.

Cost Determination Rules applicable to PHP-CCP are located at 1 TAC 355.101-114. Rules 101-114.

The PHP-CCP rules for all subsequent years are located at Title 1 TAC Section 355.8217. Rule 8217.

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 uncompensated care tool for uncompensated care costs 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.

TAC §355.8215

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 are 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 §355.8215

Cost Report – Overview

Cost Report – Overview

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

- The provider must submit the cost report to HHSC no later than **45 days** after the close of the applicable reporting period.
- A cost report period begins on October 1 and ends on September 30 of the following year.
- If a provider receives approval to participate in the program after October 1, the cost report period begins on the effective date of the supplemental payment request approval.

Cost Report – Overview

Current PHP-CCP Methodology:

FFY/DY	Report Service Period	Report Due Date
FFY 2022/DY11	10/01/2021 – 09/30/2022	11/14/2022
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 and receive credit for training for each program period in which the provider chooses to participate.
- Multiple individuals from a qualifying provider may attend and receive credit for training for each program period.
- Training is provided for each program period and is not retroactive.
- The qualifying provider must have at least one financial contact attend the annual training directly prior to the program period to participate.

Cost Report Training Requirements

- A provider that does not have a trained PHP-CCP financial contact who is an employee of the provider is prohibited from submitting a PHP-CCP application.
- Provider-contracted vendors are permitted to enter a provider's data into the cost report for any provider as a report preparer.

NO EXEMPTIONS
from the cost report training requirements can be granted

Cost Report – Overview

Cost Report Preparation & Certification

- An eligible and participating provider will prepare the cost report and will attest to, and certify through its cost report the total actual, incurred Medicaid and Uncompensated (uninsured) costs/expenditures, including the federal share and the non-federal share applicable to the cost report period.
- Costs are only eligible to be reimbursed within 24 months after the date that the cost was incurred.
- The completed cost report will be transferred via a File Transfer Protocol (FTP) and subsequently an electronic mail will need to be sent to the HHSC Provider Finance Department at PHP-CCP@hhs.Texas.gov.

Cost Report – Overview

Cost Report Expenditures

The cost report will include only allocable expenditures related to Medicaid, Medicaid Managed Care and Uncompensated Care as defined and approved in the Texas Healthcare Transformation and Quality Improvement 1115 Waiver Program. 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.

TAC §355.8215

Cost Report – Overview

For the cost report to be accurate, only the **SHADED AREAS** of the cost report are to be completed. Many worksheets (i.e. exhibits) will auto populate with information from another worksheet to avoid additional data entry and to reduce errors. Please review and verify the accuracy of all information on all exhibits before completing the cost report.

Statistical Information		
1.04	Medicaid Fee for Service (FFS) Paid Claims Amount	$ -
1.05	Total Billed Charges Associated With Medicaid FFS Paid Claims	$ -
1.06	Medicaid Managed Care Organization (MCO) - Costs for Services Provided	$ -
1.07	Total Billed Charges Associated With MCO Paid Claims	$ -
1.08	Uninsured/Uncompensated Care Reimbursement	$ -
1.09	Uninsured/Uncompensated Care Billed Amount	$ -
1.10	Total Allowable Costs for Reporting Period (Exhibit 2 - Direct Medical 2.23)	$ -
1.11	Total Paid Claims and Uninsured Reimbursement	$ -
1.12	Total Billed Charges for Reporting Period (FFS+MCO+Uninsured)	$ -
Additional Cost Data		
1.13	Medicare Costs	$ -
1.14	Self Pay, County/City Indigent Recipient Program Costs	$ -
1.15	Other Third-Party Insurance Coverage	$ -

Fill in shaded areas (yellow)

Unshaded areas (white) auto populate from other areas of worksheet

How to Complete a Cost Report

- Read the current year's Cost Report Specific Instructions (Attachment T)
- Gather all required documentation
- Review General Ledger for unallowable costs and classification errors
- Develop work papers that clearly reconcile between the provider's fiscal year end trial balance and the amounts reported on the Cost Report
- Complete all required allocations
- Check work for errors
- Maintain all documents/worksheets, etc. in one centralized location with a copy of the cost report

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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. The charity-care policy should adhere to the charity-care principles of 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.

PHP-CCP Cost Report Definitions

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.

PHP-CCP Cost Report Definitions

Cost-To-Charge ratio:

A provider's reported costs are allocated to the Medicaid program based on a cost-to-charge ratio. 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 =

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

PHP-CCP Cost Report Definitions

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 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 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. 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

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.

Uncompensated Care (UC): 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, and (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

PHP-CCP Cost Report Definitions

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

Uninsured cost: Uninsured Cost is the cost to provide services to uninsured patients as defined by the Centers for Medicare and 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.

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.

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Cost Report – Exhibit A:

Cost Report Cover Page

Exhibit A: Cover Page

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

Primary Texas Provider Identification Number (TPI): Enter the main **9-digit TPI** number for the provider that is completing the cost report (e.g., 123456789).

Primary National Provider Identification Number (NPI): Enter the main **10-digit NPI** number for the provider that is completing the cost report (e.g., 1234567890).

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

Associated National Provider Identification Number (NPIs): Enter the other associated **10-digit NPI** numbers for the provider that is completing the cost report (e.g., 1234567890, 0123456789, 1231231230, etc.).

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Exhibit A: Cover Page

COST REPORT FOR:		Associated 9-Digit Texas Provider Identification #	Associated 10-Digit National Provider Identification #
Beginning of Reporting Period:	10/1/2021	555555555	5555555555
End of Reporting Period:	9/30/2022	555555555	5555555555
		555555555	5555555555
Primary 9-Digit Texas Provider Identification # (TPI):	555555555	555555555	5555555555
Primary 10-Digit National Provider Identification # (NP	5555555555	555555555	5555555555
		555555555	5555555555
		555555555	5555555555
		555555555	5555555555
		555555555	5555555555
		555555555	5555555555
		555555555	5555555555
		555555555	5555555555
		555555555	5555555555
		555555555	5555555555
		555555555	5555555555

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Cost Report – Exhibit 1: General and Statistical Information

Exhibit 1 – General Provider Information

General Provider Information

Reporting Period – Begin Date: Enter the **Reporting Period – Beginning** date or the beginning date of the cost report period (e.g., 10/1/2010).

Reporting Period – End Date: Enter the **Reporting Period – Ending** date or the ending date of the cost report period (e.g., 9/30/2011).

Part-Year Cost Report: Enter an answer to the question "**Is Reporting Period less than a full year?"** This question identifies if the cost report is being prepared for a period that is not an entire fiscal year. If the cost report is for an entire fiscal year (October 1 – September 30), then enter **No** in the field. If the cost report is being prepared for a partial fiscal year, enter a response that explains the reason why (e.g., Supplemental Payment Request Approval was effective beginning on 7/1/20XX).

Exhibit 1 – General Provider Information

General Provider Information			HH
1.00	Reporting Period - Beginning	10/1/2021	
1.01	Reporting Period - Ending	9/30/2022	
1.02	Is Reporting Period less than a full year?	NO	
1.03	If Yes, provide a reason why.		

General Provider Information			HHSC Adj.	
1.00	Reporting Period - Beginning	[illegible]		
1.01	Reporting Period - Ending	9/30/2022		
1.02	Is Reporting Period less than a full year?	YES		
1.03	If Yes, provide a reason why.			
				A REASON MUST BE PROVIDED

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Exhibit 1 – Statistical Information

Statistical Information

This cost report uses a cost-to-billed charge ratio methodology that is applied to determine the portion of costs eligible for reimbursement under the Direct Medical settlement exhibit of the cost report (see Exhibit 2).

Statistical Information		
1.04	Medicaid Fee for Service (FFS) Paid Claims Amount	$ -
1.05	Total Billed Charges Associated With Medicaid FFS Paid Claims	$ -
1.06	Medicaid Managed Care Organization (MCO) - Costs for Services Provided	$ -
1.07	Total Billed Charges Associated With MCO Paid Claims	$ -
1.08	Uninsured/Uncompensated Care Reimbursement	$ -
1.09	Uninsured/Uncompensated Care Billed Amount	$ -
1.10	Total Allowable Costs for Reporting Period (Exhibit 2 - Direct Medical 2.23)	$ -
1.11	Total Paid Claims and Uninsured Reimbursement	$ -
1.12	Total Billed Charges for Reporting Period (FFS+MCO+Uninsured)	$ -

Exhibit 1 – Statistical Information

Summary of Payments and Billed Charge Data (Applicable to Cost Report)

Medicaid Fee-for-Service Paid Claims Amount: The Medicaid fee-for-service paid claims amount entered must only be for **dates of service** during the cost report period.

Total Billed Charges Associated with Medicaid FFS Paid Claims: The total billed charges associated with Medicaid FFS paid claims entered must only be 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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Exhibit 1 – Statistical Information

Medicaid Managed Care Organization (MCO) Paid Claims Amount: The Medicaid MCO paid claims amount for services entered should be for dates of service during the cost report period.

Total Billed Charges Associated with MCO Paid Claims: The total billed charges associated with MCO paid claims entered must only be 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.

Uninsured/Uncompensated Care – (UC) Reimbursements Received Associated with UC Costs: Enter the reimbursements received associated with UC Claims for the applicable cost report period identified on the form. The total reimbursements received associated with UC claims entered must only be for dates of service during the cost report period.

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Exhibit 1 – Statistical Information

Uninsured/Uncompensated Care – (UC) Uninsured Billed Amounts: Enter the total **UC** Charity and Bad Debt amounts billed for services provided for the applicable Cost Report period identified on the form. The UC costs for services entered should be for dates of service during the cost report period and must exclude all unfunded Medicaid and Medicare costs. Billed charges are based on the local chargemaster that sets the usual and customary rate for services.

Total Allowable Costs for Reporting Period: The total allowable costs are only for dates of service during the cost report period.

Total Billed Charges for Reporting Period: The Total Billed Charges calculated are for the applicable cost report period identified on the form less the total allowable costs and less any reimbursements received. The total billed charges entered are only for dates of service during the cost report period.

Exhibit 1 – Additional Cost Data

Additional Cost Data (For Informational Purposes Only)
In addition to the statistical information entered for Cost Reporting period, other cost data is being requested.

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.

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.

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.

Cost Report – Exhibit 2:
Direct Medical

Exhibit 2

Exhibit 2 identifies and summarizes from other exhibits all services costs within the cost report. Much of the information contained within this exhibit is pulled from either Exhibit 5 or Exhibit 6; however, there are unique items of cost that are identified in this exhibit.

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

This Exhibit sums the personnel expenses and adds additional costs to calculate the total cost of Medical and Uncompensated Care Services.

Exhibit 2

Direct cost methods must be used.

Direct cost means allowable costs for medical services for the benefit of, and directly attributable to, a specific service delivery component must be directly charged to that particular business component. Providers may use reasonable cost allocation methods for administrative or operational costs that are related to direct service delivery.

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Cost Allocation – Direct Cost

Direct costs are those that can be identified specifically with a particular final cost objective.

Direct costs chargeable to Federal awards are:

- Compensation of employees for the time devoted and identified specifically to the performance of those awards
- Cost of materials acquired, consumed, or expended specifically for the purpose of those awards
- Equipment and other approved capital expenditures
- Travel expenses incurred specifically to carry out the award
- Direct cost of a minor amount may be treated as an indirect cost for reasons of practicality where such accounting treatment for that item of cost is consistently applied to all cost objectives.

Exhibit 2

Payroll Expenses

This section of the exhibit includes all personnel related expenditures and hours for the job classifications identified. **<u>This is populated using data entered in Exhibit 6</u>.**

PAYROLL EXPENSES			Amount
2.00	Employee Gross Salary (Enter on Exhibit 6 Schedule B)		$ -
2.01	Employee Benefits (Describe in External Support)		$ -
2.02	Employer Retirement Contribution		$ -
2.03	Employer FICA Payroll Taxes		$ -
2.04	Employer Other Payroll Taxes		$ -
2.05	State Unemployment Payroll Taxes		$ -
2.06	Federal Unemployment Payroll Taxes		$ -
2.07	Unemployment Compensation (Reimbursing Employer)		$ -
2.08	Total Staff Costs (sum items 2.00 thru 2.07)		$ -

Exhibit 2

Other Costs

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

All costs identified in the section of the Exhibit are supported by supplemental schedules to the cost report and will be supplied at the time of cost report submittal.

OTHER COSTS		
2.09	Supplies & Materials:	
2.10	Supplies & Materials Non-Medical (Provide additional support)	$ -
2.11	Supplies & Materials Medical (Provide additional support)	$ -
2.12	Equipment:	
2.13	Equipment Non Medical (Provide additional support)	$ -
2.14	Equipment Medical (Provide additional support)	$ -
2.15	Support Services (IT, Dispatch, Call Handling, etc.)	$ -
2.16	Other Costs (Provide additional support for all other costs)	$ -
2.17	Depreciation (Exhibit 5 Schedule A)	$ -
2.18	Total Direct Other Costs (sum items 2.09 through 2.17)	$ -
2.19	Medical Clients Served	-
2.20	All Clients Served (Medical + Non-Medical)	-
2.21	Allocation Ratio (2.19 divided by 2.20)	0.00%
2.22	Total Direct Medical Other Costs	$ -
2.23	TOTAL Staff and Direct Medical Other Costs (sum items 2.08 and 2.22)	$ -

Exhibit 2

Supplies and Materials Costs: Please see Appendix A Exhibit 2 in Attachment T for the list of supplies, materials, and equipment. Supplies and materials include, but are not limited to, the following:

- Medical supplies
- Office supplies
- Maintenance supplies
- Medical materials

Depreciable Costs: All assets must be depreciated. Asset costs are only accepted on the Cost Report if the asset is depreciated in accordance with the Medicare cost report requirements. If the item is not depreciable pursuant to the Medicare requirements, prior approval from HHSC and CMS is required before recording the entry on the Cost Report.

Exhibit 2

Support Services Costs: Enter the amount of **Support Services** expenditures incurred by the provider during the cost report period. Support Services expenditures may include:

- Personnel
- Non-personnel expenditures depending if the personnel expenditures are represented in the job classification categories identified in this Exhibit and detailed in Exhibit 6.
- Support Services expenditures include, but are not limited to
  - Information technology salaries,
  - Benefits, and
  - Operating expenditures.

Other Costs: Enter the amount of **Other** expenditures incurred by the provider during the Cost Report period. Other expenditures may include personnel and non-personnel expenditures depending if the personnel expenditures are represented in the job classification categories identified in this Exhibit and detailed in Exhibit 6. Other expenditures include, but are not limited to, depreciation expenses (Exhibit 5).

Exhibit 2

Reductions to Allowable Costs: This section of the exhibit includes reductions to expenditures identified in Exhibit 6. Identified reductions from Exhibit 6 are subtracted to calculate the adjusted amount of Direct Medical Costs allowable as part of the cost report.

Cost Settlement Calculation: Period of Service for Applicable Cost Report Period: Enter the **Period of Service** for the applicable cost report period. Example: 10/01/20XX to 09/30/20XX. For partial year cost reports, enter the period of service applicable only to the time frame a cost report is being submitted to cover.

Total Billed Charges for Period of Service: The **Total Billed Charges** for the applicable period of service. (No entry is required).

Total Allowable Costs for Period of Services: The total allowable costs entered into the cost report, less any “other federal funding” received. (No entry is required).

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Exhibit 2

Allocation Ratio: Enter the number of Medical Clients Served by the provider during the Cost Report period. Enter the number of All Clients Served by the provider during the Cost Report period, both medical and non-medical. The Allocation Ratio is calculated by dividing the medical clients served over all clients served. The total direct other costs is multiplied by the allocation ratio to get the Total Direct Medical Other Costs.

Because all costs must be related to Medicaid covered services and providers offer a variety of services, HHSC may require a provider to use a separate allocation mechanism for the Allocation Ratio that more accurately allocates direct and indirect costs. Further, at a provider's request, HHSC may allow for a separate allocation mechanism for the Allocation Ratio that more accurately allocates direct and indirect costs, so long as the provider is able to provide support and justification.

Exhibit 2

Cost-to-Charge Ratio: This ratio results from dividing a provider's Total Allowable Costs for the reporting period by the provider's Total Billed Charges for the same period.

Total Charges Associated with Medicaid, Paid Claims, Medicaid Managed Care Claims, and Uncompensated Care Paid Fees: Enter the **Total Billed Charges Associated with Medicaid FFS and Medicaid Managed Care Paid Claims** for the period of service applicable to the cost report.

Total Computable: The total Medicaid Allowable Costs for the period of service applicable to the cost report. The **Total Computable** amount is reduced by the amount of Medicaid Claims paid (Interim Payments) to a provider for the service period applicable to the cost report. This calculation is equal to the **Settlement Amount** for the reporting period.

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Cost Report – Exhibit 3 & 4:

Cost Report Certification & Certification of Funds

Report Certification(s)

<u>Cost Report Certification:</u>

Is required and formally acknowledges that the cost report is true, correct and 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.
- **<u>The responsible party's signature must be notarized.</u>**

Report Certification(s)

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.**

Cost Report – Exhibit 5:

Schedule A (Depreciation Schedule)

Depreciation

The purpose of depreciation is to apply the expense portion of an asset that relates to the revenue generated by the asset. As referenced in 2 CFR 225, 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.

2 CFR 225

Depreciation

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

TAC §355.105

Depreciation

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

TAC §355.105

Depreciation – Vehicles

Depreciation of vehicles is limited to only the vehicles used in the delivery and/or transportation of recipients to and from a Title XIX medical service. No other vehicles are to be included in the costing/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.

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Depreciation – Building

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
- Any portion of the cost of building donated by the Federal Government

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TAC §355.103

Depreciation – Building

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

Or

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

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TAC §355.103

Exhibit 5 – Depreciation

SCHEDULE A

DEPRECIATION -- PUBLIC HEALTH PROVIDER CHARITY CARE PROGRAM -- (Straight-Line Method Only)

A	B	C	D	E	F	G	H	I	K	L	M	N	O	P	Q
Description of Asset	Month/Day/Year Placed in Service	Years of Useful Life	Cost	Salvage Value	Prior Period Accumulated Depreciation	When Asset Will Meet End of Useful Life	Asset Disposed of in FFY? (Y/N)	Month/Day/Year of Disposal (if Y in Column H)	Useful Life Begins This Period	Beginning Date	Months of Useful Life	Useful Life Ends in This Period	Ending Date	Months of Depreciation	HHSC Allowable Depreciation For Reporting Period
BUILDINGS:															$ -
				$ -		1/0/1900			N	10/1/2021	0	N	9/30/2022	12	$ -
				$ -		1/0/1900			N	10/1/2021	0	N	9/30/2022	12	$ -
				$ -		1/0/1900			N	10/1/2021	0	N	9/30/2022	12	$ -
				$ -		1/0/1900			N	10/1/2021	0	N	9/30/2022	12	$ -
				$ -		1/0/1900			N	10/1/2021	0	N	9/30/2022	12	$ -
				$ -		1/0/1900			N	10/1/2021	0	N	9/30/2022	12	$ -
				$ -		1/0/1900			N	10/1/2021	0	N	9/30/2022	12	$ -
				$ -		1/0/1900			N	10/1/2021	0	N	9/30/2022	12	$ -
				$ -		1/0/1900			N	10/1/2021	0	N	9/30/2022	12	$ -
				$ -		1/0/1900			N	10/1/2021	0	N	9/30/2022	12	$ -
				$ -		1/0/1900			N	10/1/2021	0	N	9/30/2022	12	$ -
				$ -		1/0/1900			N	10/1/2021	0	N	9/30/2022	12	$ -
				$ -		1/0/1900			N	10/1/2021	0	N	9/30/2022	12	$ -
				$ -		1/0/1900			N	10/1/2021	0	N	9/30/2022	12	$ -
				$ -		1/0/1900			N	10/1/2021	0	N	9/30/2022	12	$ -
													TOTAL		$ -

Exhibit 5 – Depreciation

Asset Description: The name or account code, or both, will suffice. If there is the need to add additional lines, please do so.

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

Years Useful Life: Enter the number as identified on the provider's depreciation schedule (e.g., 20 for twenty years of useful life).

Cost: Enter the asset's initial **cost** as identified on the provider's depreciation schedule.

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Exhibit 5 – Depreciation

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 is the total amount of depreciable expenses to date related to the depreciable asset.

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

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

Exhibit 5 – Depreciation

SCHEDULE A

DEPRECIATION -- PUBLIC HEALTH PROVIDER CHARITY CARE PROGRAM -- (Straight-Line Method Only)

A	B	C	D	E	F	G	H	I	K	L	M	N	O	P	Q
Description of Asset	Month/Day/Year Placed in Service	Years of Useful Life	Cost	Salvage Value	Prior Period Accumulated Depreciation	When Asset Will Meet End of Useful Life	Asset Disposed of in FFY? (Y/N)	Month/Day/Year of Disposal (if Y in Column H)	Useful Life Begins This Period	Beginning Date	Months of Useful Life	Useful Life Ends in This Period	Ending Date	Months of Depreciation	HHSC Allowable Depreciation For Reporting Period
BUILDINGS:															$ -
				$ -		1/0/1900			N	10/1/2021	0	N	9/30/2022	12	$ -
				$ -		1/0/1900			N	10/1/2021	0	N	9/30/2022	12	$ -
				$ -		1/0/1900			N	10/1/2021	0	N	9/30/2022	12	$ -
				$ -		1/0/1900			N	10/1/2021	0	N	9/30/2022	12	$ -
				$ -		1/0/1900			N	10/1/2021	0	N	9/30/2022	12	$ -
				$ -		1/0/1900			N	10/1/2021	0	N	9/30/2022	12	$ -
				$ -		1/0/1900			N	10/1/2021	0	N	9/30/2022	12	$ -
				$ -		1/0/1900			N	10/1/2021	0	N	9/30/2022	12	$ -
				$ -		1/0/1900			N	10/1/2021	0	N	9/30/2022	12	$ -
				$ -		1/0/1900			N	10/1/2021	0	N	9/30/2022	12	$ -
				$ -		1/0/1900			N	10/1/2021	0	N	9/30/2022	12	$ -
				$ -		1/0/1900			N	10/1/2021	0	N	9/30/2022	12	$ -
				$ -		1/0/1900			N	10/1/2021	0	N	9/30/2022	12	$ -
				$ -		1/0/1900			N	10/1/2021	0	N	9/30/2022	12	$ -
				$ -		1/0/1900			N	10/1/2021	0	N	9/30/2022	12	$ -
													TOTAL		$ -

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.

Other Assets

Reporting Procedures:

Use minimum schedules consistent with "Estimated Useful Lives of Depreciable Hospital Assets," published by the American Hospital Association.

Examples:

- Building equipment
- Buildings and grounds improvements and repairs
- Durable medical equipment, furniture, and appliances
- Power equipment and tools used for buildings and grounds maintenance

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Depreciation VS. Actual Expense

Repairs and Maintenance:

Ordinary repairs:

- Recurring
- Usually involve expenditures for parts and labor to keep the asset in operating condition

Examples:

- Painting
- Copy machine repair
- Oil changes

Expense these costs as incurred

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Exhibit 5 – Depreciation

Repairs and Maintenance

Extraordinary repairs:

- Expenditures not normally recurring
- Usually increase the value of an asset

Examples:

- Vehicle overhauls
- Replacing a roof
- Strengthening the foundation of a building

Exhibit 5 – Depreciation

Unallowable depreciation/amortization:

- Depreciation and amortization for unallowable assets
- Amounts in excess of those using the straight-line method (GAAP)
- Planning/evaluation expenses for depreciable assets not purchased and used in contracted services
- Missing information
- Reportable basis
- Calculations, formulas, etc.

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Cost Report – Exhibit 6:
Schedule B (Payroll & Benefits)

Exhibit 6 – Payroll & Benefits

This exhibit includes the salary and benefits and appropriate reductions related to contracted and employed staff of the provider applicable to Medicaid, Medicaid Managed Care and Uncompensated Care. For this Exhibit, all employed and contracted staff related to the provision of services should be identified here. Any payroll related item that is not directly related to medical services should not be included in this section.

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Exhibit 6 – Payroll & Benefits

SCHEDULE B
PAYROLL AND BENEFITS

EMPLOYEE INFORMATION					PAYROLL AND BENEFITS									
Employee # (NO personal identifiers i.e. SSN)	Last Name	First Name	Job Title / Credentials	(E)mployee or (C)ontracted	Gross Salary	Total Hours Worked	Contractor Payments	Employee Benefits	Employer Retirement Contribution	Employer - FICA Payroll Taxes	Employer - Other Payroll Taxes	State Unemployment Payroll Taxes	Federal Unemployment Payroll Taxes	Unemployment Compensation (Reimbursing Employer)
TOTAL					$ -	-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -

Exhibit 6 – Payroll & Benefits

Employee #: Enter the **Employee #** for the employee for which a portion of their salary and benefits must be reduced from the total allowable costs.

Last Name: Enter the **Last Name** of the employee for which a portion of their salary and benefits must be reduced from the total allowable costs.

First Name: Enter the **First Name** of the employee for which a portion of their salary and benefits must be reduced from the total allowable costs

Job Title/ Credentials: Enter the **Job Title / Credentials** of the employee for which a portion of their salary and benefits must be reduced from the total allowable costs.

Employee (E) /Contractor (C): Enter the appropriate designation, **either an E or a C,** of the employee for which a portion of their salary and benefits must be reduced from the total allowable costs. E designates an employee; C designates a contractor.

Exhibit 6 – Payroll & Benefits

Gross Salary: Enter the amount for the employee for which a portion of their salary and/or benefits must be reduced from the total allowable costs.

Contractor Payments: Enter the amount of **Contractor Payments** for the employee for which a portion of their salary and/or benefits must be reduced from the total allowable costs.

Employee Benefits: Enter the amount of **Employee Benefits** for the employee for which a portion of their salary and/or benefits must be reduced from the total allowable costs. This includes all benefits that are not discretely identified in this Exhibit.

Employer Retirement: Enter the amount of **Employer Retirement** expenditure for the employee for which a portion of their salary and/or benefits must be reduced from the total allowable costs.

Exhibit 6 – Payroll & Benefits

FICA: Enter the employer portion amount of **FICA** expenditure for the employee for which a portion of their salary and/or benefits must be reduced from the total allowable costs.

Payroll Taxes: Enter the employer portion amount of **Other Payroll Taxes** expenditure for the employee for which a portion of their salary and/or benefits must be reduced from the total allowable costs.

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Exhibit 6 – Payroll & Benefits

FED FUNDING REDUCTION			
Position Fully or Partially Funded By Fed Funds or Grants? Yes or No	If Yes, Amount of Federal Funding	Other Amounts To Be Removed	Total Reduction
			$ -
			$ -
			$ -
			$ -
			$ -
			$ -
			$ -
			$ -
			$ -
			$ -
			$ -
			$ -
			$ -
			$ -
			$ -
			$ -
			$ -
	$ -	$ -	$ -

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Exhibit 6 – Payroll & Benefits

Federal Funding Reductions

This section of the Exhibit is designed to identify the federal funding or other payroll and benefit expenditure reduction necessary for the specific job classifications identified. This section of the Exhibit is 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.

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Exhibit 6 – Payroll & Benefits

Allocated Funded Positions Entry: Enter the appropriate designation, **either a Y or an N**, for the employee for which a portion of their salary and/or benefits must be reduced from the total allowable costs. A "Y" in this field designates an employee for which a portion or all of their salary and benefit expenditures are funded by federal funds or grants. An "N" in this field designates an employee for which a portion or all of their salary and benefit expenditures are not funded by federal funds or grants but still need to be removed from allowable expenditures as reported on the Cost Report.

Federal Funding: If the answer to the field previously is "Y," then enter the amount of **Federal Funding** related to the employee's salary and benefits that must be reduced from the total allowable costs reported on the Cost Report.

Other Funds: Enter the amount of **Other Amount to be Removed** related to the employee's salary and benefits that must be reduced from the total allowable costs as reported on the Cost Report.

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Exhibit 6 – Payroll & Benefits

Payroll and Benefits Entry: Enter the amount of Salary and appropriate benefits for all other personnel and staff related to the job classifications identified. Salary or benefit expenditures do not need to be reduced from the total allowable costs.

Supplemental Schedule: A provider may enter information on a summary basis rather than entering each employee individually if a supplemental personnel schedule is provided.

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Cost Report – Exhibit 7: Schedule C (Cost Allocation Methodologies)

Purpose of Cost Allocation

The purpose of a cost allocation plan is to summarize, in writing, the methods and procedures the organization will use to allocate costs to various programs, grants, contracts, and agreements.

General guidance regarding cost allocation for federal grant funded programs is provided by the Office of Management and Budget (OMB) for state, local, and Indian tribal governments. 2 CFR 225 applies.

2 CFR 225

Cost Accounting Standards (CAS)

2 CFR 225 applies to Governmental entities and municipalities; however, Cost Accounting Standards (CAS) can provide useful information to a governmental entity.

CAS standards are designed "to achieve uniformity and consistency in cost accounting practices."

2 CFR 225

Cost Allocation Methodology

Costs are allocated using CMS-approved statistics to facilitate the identification of costs associated with Medicaid, Medicaid Managed Care and Uncompensated Care costs.

These costs may be included as part of the allocation methods utilized in the PHP-CCP Cost Report.

Keep in mind that supporting documentation must be kept for all costs included in the cost report.

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Cost Allocation – Central Office

Administrative costs are indirect costs produced by administrative functions. Administrative costs can be directly charged or shared. If these costs are shared, they are considered central office costs and must be allocated.

Administrative functions include:

- General Administrative Oversight
- Central Management
- Personnel Functions
- Accounts Payable
- Accounts Receivable
- General Ledger Accounting Functions
- Risk Management Functions
- Financial Statement Functions
- Payroll Functions
- Benefit Management Functions
- Purchasing Functions
- Any other Administrative-Type Function

2 CFR 225

Cost Allocation – Central Office

Costs related to administrative functions include:

- Salaries/wages
- Payroll taxes
- Employee benefits
- Supplies
- Office space
- Operations costs (travel/training)

Cost Allocation- Indirect Cost

Indirect costs are incurred costs identified that have two or more cost objectives but are not specifically identified with any final cost objective.

These shared costs may include:

- Building/facility rent or lease
- Utilities costs
- Telecommunications costs
- Administrative staff salaries/wages
- Advertising expenses
- Travel expenses

Allocation of Time – Time Sheets

Must properly document any staff whose duties include:

- Multiple direct service types, both direct and indirect service component types, and/or
- Both direct hands-on support and first-level supervision of direct care workers.

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Must maintain:

- Continuous record of time on a daily basis throughout the entire reporting period
- Records indicating the direct charge of ALL hours worked in each job function and activity for the entity

Allocation of Time – Time Sheets

Time sheets must include the following:

- Employee Name
- Date
- Start and Stop Time
- Total Hours Worked
- Time worked providing direct services in the program (in increments of 30 minutes or less)
- Time worked performing other functions
- Paid time off
- Appropriate Signatures and Dates

TAC §355.105

Time Sheet Example

HHSC Central Office Admin Support Daily Time Sheet

EMPLOYEE NAME: Marium DeMarco DATE: 10/31/11

TIME(hh:mm)		Duties	Cost Centers by Department (Enter time in minutes)						
BEGINNING	ENDING	Activities Performed	HR-1000	Legal-2000	Finance-3000	EMS-2000	Fire 5000	PD-6000	*Shared Admin costs
8:00 AM	9:30 AM	Payroll	90						
9:30 AM	10:30 AM	Accounting			60				
10:30 AM	11:15 AM	Meeting EMS				45			
11:15 AM	12:30	Meeting FIRE Dept					45		
12:30 PM	1:00 PM	Travel Back to Office				30	30		
1:00 PM	2:00 PM	Lunch							60
1:30 PM	2:30 PM	Voucher Processing			60				
2:30	3:30	AMB Waiver Issues							
3:30	4:30 PM	Annual Leave / Vacation							60
Total Minutes per Cost Center			90	0	120	75	75	0	120

* Shared Admin Costs - Paid Lunches; Annual Leave; Sick Leave, Jury Duty; etc.

Legend		Daily Summary		Allocation of Shared Time		
Department	Cost Center	Cost Center	Total Minutes	Alloc/%	Alloc Time	Total Time
Central Office	HHSC-1000	HHSC-1000	90.00	25%	30	120
Legal	HHSC-2000	HHSC-2000	0.00	0%	0	0
Finance	HHSC-3000	HHSC-3000	120.00	33%	40	160
EMS	HHSC-4000	HHSC-4000	75.00	21%	25	100
Fire	HHSC-5000	HHSC-5000	75.00	21%	25	100
PD	HHSC-6000	HHSC-6000	0.00	0	0	0
Shared Admin Time	HHSC-7000	HHSC-7001	120.00	360.00	120.00	480
	Total Minutes		480.00			

Jane Smith, CPA, MBA 9/30/2011

Signature: Date:

Jerry Pritchard, City Manager 11/1/2011

Supervisor Signature/ Title: Date:

Cost Report – Allowable Costs

Allowable vs. Unallowable Costs

Cost are only allowable if they are **reasonable** and **necessary**.

Reasonable Cost: The provider seeks to minimize costs through arm's-length transactions. The amount expended does not exceed what a prudent, cost-conscious buyer pays for a given item or service.

Necessary Cost: Those costs that are appropriate for developing and maintaining the required standard of operation for providing client care.

TAC §355.102

Allowable Costs: Salary, Wages, and Benefits

Allowable employee benefits are reported as either:

Salaries and wages: Benefits reported as salaries and wages are directly charged to the individual employee to include paid vacation days, paid holidays, paid sick leave, other paid leave, and bonuses.

Employee benefits: Employer contributions to deferred compensation plans, retirement funds or pension plans, certain employer-paid health/medical/dental and disability insurance premiums and paid claims, employer-paid life insurance premiums, employer-paid child daycare for children of employees.

Costs applicable to specific cost areas.

TAC §355.103

Allowable Costs: Other Benefit Expenses

Benefits that are reported as costs applicable to specific cost areas include:

- Employer-paid training/educational costs
- Employee relations costs
- Uniforms
- Mileage reimbursement

Note:
Report as a salary if your entity deducts taxes from the reimbursement.

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TAC §355.103

Allowable Costs: Other Benefit Expenses

Providers must maintain documentation that clearly identifies each type of compensation. Examples of required documentation include:

- Insurance policies
- Provider benefit policies
- Records showing paid leave accrued and taken
- Documentation to support hours (regular & overtime)
- Hours worked and wages paid
- Mileage logs
- Travel Allowances

TAC §355.105

Allowable Costs: Accounting/Audit/Legal Fees

Documentation for accounting, auditing, and legal fees that are billed on an hourly basis; the allowable portion of legal retainers must include:

- The amount of time spent on the activity
- A written description of the activity performed
- The person performing the activity
- The hourly billing amount of the person performing the activity

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TAC §355.105

Allowable Costs: Employer Expenses

Interest Expense:

- Loan Documentation:
  - Signed copy of loan
  - Explanation of purpose of loan
  - Documentation of use of proceeds
  - Evidence of systematic principal and interest payments
  - Substantiation of costs of securing loan

TAC §355.103

Allowable Costs: Training Costs

The following training expenses are ALLOWABLE on the cost report if the training has a direct relationship to the job:

- On-The-Job Training
- Instructors Costs
- Materials
- Registration Fees

TAC §355.103

Allowable Costs: Travel Costs

The maximum for lodging per diem and meals per diem costs is 150 percent of the General Services Administration (GSA)'s federal travel rates for maximum lodging and meal reimbursement rates. The GSA's travel rates may be found at:

https://www.gsa.gov/travel/plan-book/per-diem-rates

The GSA recently developed a travel tool that allows individuals to enter in all of the pertinent travel information relating to: Per Diem Meals & Incidental Expenses (IE) Airfares Hotels Privately Owned Vehicle (POV) Mileage To calculate the total costs associated with each trip for that calendar year.

TAC §355.103

Allowable vs. Unallowable Costs

Memberships, Subscriptions, Lobbying, Contributions, and Donations:

Costs for membership in professional associations directly and primarily concerned with the provision of services.

Allowable:

- Professional association dues
- Dues or fees to maintain professional accreditation

Unallowable:

- Lobbying or campaign contributions
- Civic organizations
- Non-professional organizations

Cost Report – Exhibit 8:

Schedule D (Collection)

Reasonable Collection Effort

To be considered a reasonable collection effort, a provider's effort to collect fees for services rendered must involve the issuing of a bill on, or shortly after, discharge or death of the beneficiary to the party responsible for the patient's personal financial obligations. It also includes other actions such as subsequent billings, collection letters, telephone calls, or personal contacts with this party which constitute a genuine, rather than a token, collection effort. The provider's collection effort may include using or threatening to use court action to obtain payment.

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Reasonable Collection Effort

If a separate Texas Administrative Code (TAC) rule, statute, or other state law does not allow for providers to collect fees from clients, providers must provide the rule under which collection is prohibited in place of this documentation.

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Reasonable Collection Effort

Collection Agencies:

A provider's collection effort may include the use of a collection agency in addition to or in lieu of subsequent billings, follow-up letters, telephone, and personal contacts. Where a collection agency is used, it is expected that the provider refers all uncollected patient charges of like amount to the agency without regard to the class of patient. The “like amount” requirement may include uncollected charges above a specified minimum amount. Where a collection agency is used, the agency's practices may include using or threatening to use court action to obtain payment.

Documentation Required:

The provider's collection effort should be supported by documentation in the patient’s file. Some examples of supporting documentation include: copies of the bill(s), follow-up letters, reports of telephone and personal contact, etc.

Collection Fees: Presumption of Uncollectability

Collection agency utilization:

Where a provider utilizes the services of a third-party, non-related collection agency, and the reasonable collection effort is applied, the fees the collection agency charges the provider are recognized as an allowable administrative cost of the provider.

When a collection agency obtains payment for an account receivable, the full amount collected must be credited to the patient's account and the collection fee charged to administrative costs.

Collection Fees: Presumption of Uncollectability

For example:

If an agency collects $40 from the patient/responsible party, and its fee is 50 percent, the agency keeps $20 as its fee for the collection services and remits $20 (the balance) to the provider. The provider records the full amount collected from the patient by the agency ($40) in the patient's account receivable and records the collection fee ($20) in administrative costs. The fee charged by the collection agency is merely a charge for providing the collection service; therefore, it is not treated as a bad debt.

Presumption of Non-collectability:

If after reasonable and customary attempts to collect a bill, the debt remains unpaid more than 120 days from the date the first bill is mailed to the beneficiary, the debt may be deemed uncollectible.

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Cost Report – Walkthrough

Reviews & Appeals

Cost Report Submission/Review Process

- Submitted cost reports are logged and tracked by HHSC
- 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 review/field audit
  - Reviewing each cost report on an individual basis
- HHSC completes reviews within 90 days of cost report submission

Desk Reviews and Field Audits

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 Audit staff within 10 working days of notification. 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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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 objective (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.

Desk Reviews and Field Audits

HHSC e-mails 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

Informal Review Requests

- Due within 30 calendar days of notification.
- Must include items in dispute, recommended resolution, supporting documentation.
- Must be signed by 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 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

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).

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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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Questions?