Cost Allocation Methodologies

Texas Health and Human Services Commission (HHSC) previously changed its practice in regards to allowable HSL cost allocation methods for purposes of the Disproportionate Share Hospital (DSH) examination. These changes were effective for DSH Part II Surveys under initial examination during the 2013 Medicaid State Plan rate year, and remain effective for the 2019 Medicaid State Plan rate year. HHSC made these revisions to ensure cost allocation methods utilized by DSH hospitals correspond with CMS' *General DSH Audit and Reporting Protocol* (Protocol). The Protocol requires hospitals to allocate the cost of Medicaid and uninsured days and charges by hospital cost center, as noted in the excerpt below:

> "The auditable documentation must show that the program days and charges pertain: **a) only to services furnished by the hospital and its departments and not by any non-hospital component (even if such component is deemed to be hospital-based); b) only to inpatient hospital services and not services furnished by practitioners which can be billed separately as professional services;** and c) only to services furnished to individuals who have no source of third party coverage (services furnished to individuals who are covered only by state-only/local governmental programs may be included). As required by the 2552-96 cost report apportionment process, **the program data must be reported by hospital cost centers.**"
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> "By applying the program days defined above to the cost-report-computed per diems and applying the program charges defined above to the cost-report-computed cost-to-charge ratios, and by following the established 2552-96 cost reporting and apportionment process, the hospital will determine its hospital uninsured inpatient cost."

As emphasized above, Medicare costing principles require that "program data must be reported by hospital cost centers." This means hospitals must have revenue or department codes that illustrate how their cost is reported (cross-walked) by cost center. It is a requirement that hospitals provide revenue code level detail in all self-reported claims supporting documentation. CMS provides revenue code detail in its paid claims listing specifically for this purpose. States also provide revenue code detail in their Medicaid Management Information System (MMIS) data. When a state is unable to provide this level of detail due to system restrictions, an alternative approach is necessary. However, even in those instances, a hospital should base its allocation of days and charges on internally generated revenue code or department code crosswalks.

To assist hospitals in the accurate and uniform completion of revenue code crosswalks, Myers and Stauffer, LC (MSLC) will provide a Revenue/Cost Center Code Crosswalk Template file in Excel format. It will be referred to here and throughout the DSH examination process as "Exhibit X - Crosswalk."

Required Cost Allocation Methodologies by Payer Type

As noted previously, effective for the 2013 DSH examination, HHSC changed its practice regarding cost allocation methodologies which are considered acceptable for DSH hospitals to utilize. Summarized in the table below are those methodologies by payer type. The DSH Survey will be considered to be in violation of HHSC practice if any methodology other than those in the table below is utilized without prior approval.

Payer Type	HHSC Approved Methodology
Medicaid FFS Primary (Non-Crossover) Services	Hospitals must use a Revenue Code Crosswalk when revenue codes are available. If revenue codes are not available, hospitals must use a HCPCS and/or Cost Center Code Crosswalk. MSLC will provide the TMHP Cost Center Code Description file. These crosswalks can be created to allocate to one cost center per revenue/HCPCS/cost center code or many cost centers per revenue/HCPCS/cost center code. The crosswalk submitted by the hospital must follow the format presented in Exhibit X.
Medicaid MCO Services (may include some MMP claims, similar to FFS Crossover below)	Hospitals must use a Revenue Code Crosswalk. This crosswalk can be created to allocate to one cost center per revenue code or many cost centers per revenue code. The crosswalk submitted by the hospital must follow the format presented in Exhibit X.
Medicare/Medicaid FFS Crossover Services & MMP Claims (MMP claims are those associated with dual eligible patients under the Texas Dual Eligible Integrated Care Project – see disclosure in Notification Letter)	Crossover claims are adjudicated by TMHP at the header level. The detail levels associated with this claim type are not subject to the same adjudication edits as FFS Primary claims by TMHP. As such, the claim details may not be accurate. In lieu of a Revenue Code Crosswalk, hospitals should utilize a percentage allocation schedule using Title XVIII values from the Medicare Cost Report. This methodology would first calculate routine charges using a Title XVIII calculated charge per diem. MSLC will provide a template that may be used to calculate and support this allocation methodology. Alternatively, hospitals may use a revenue code-derived allocation schedule based on an internally generated Revenue and Usage Report for Medicare/Medicaid FFS Crossover services. The report should approximate the day and charge volume found in state-provided MMIS data. Due to timing differences in internally generated reports and MMIS crossover data, it is anticipated that these reports will not be an exact match to MMIS data.

Medicare/Medicaid FFS Crossover Services & MMP Claims (cont.)	The process to complete this allocation is as follows: (1) Create a report of Medicare/Medicaid FFS and MMP Crossover services (days and charges) for the cost report year summarized by revenue code; (2) Allocate each revenue code to the appropriate cost center(s) just as you would any other payer type; (3) Use this grouping to create a charges per cost center to total charges percentage allocation, and a routine days per cost center to total routine days allocation taking care to only report routine charges in routine cost centers; (4) Utilize these percentages to allocate the total MMIS Medicare/Medicaid FFS and MMP Crossover days and charges to the appropriate cost center.
Medicaid Eligible Services Not Billed to Medicaid	Hospitals must use a Revenue Code Crosswalk. This crosswalk can be created to allocate to one cost center per revenue code or many cost centers per revenue code. The crosswalk submitted by the hospital must follow the format presented in Exhibit X.
Uninsured Services (includes State/Local-Only Indigent Care Program claims)	Hospitals must use a Revenue Code Crosswalk. This crosswalk can be created to allocate to one cost center per revenue code or many cost centers per revenue code. The crosswalk submitted by the hospital must follow the format presented in Exhibit X.
Out-of-State Medicaid Services (All Payer Types)	Hospitals must use a Revenue Code Crosswalk. This crosswalk can be created to allocate to one cost center per revenue code or many cost centers per revenue code. The crosswalk submitted by the hospital must follow the format presented in Exhibit X.