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**Completing and
Submitting the 2024
Disproportionate Share
(DSH) and DY 13

Uncompensated Care
(UC) Application**



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Agenda

- General Information on Application Processes
- Review DSH and UC Application
- CHIRP Adjustment Appeal Process
- State Payment Cap Appeal Processes
- Application Submission
- Q&A



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Important DSH/UC Related Dates

- **October 20, 2023:** All hospital applications were sent to the email addresses given by providers when the applications were requested.
- **October 20- November 20, 2023,** Application Submission Period.
- **November 20, 2023:** Deadline to request extension for application submission per TAC 355.8066. This is distinct from SPC appeal submissions which do not allow extensions.
- **October 20, 2023 – November 20, 2023:** Deadline to submit SPC appeal to TMHP. Extensions are not available for SPC appeal **submissions.**
- **December 05, 2023:** Deadline to submit applications for providers who requested an extension.
- **Mid December 2023 – March 2024:** HHSC will review 2024 DSH/UC Applications and correspond with providers.
- **April 2024:** DSH Qualification results will be sent to providers.
- **June 2024:** All 2024 Qualifying DSH providers eligible for payment paid.
- **September 2024:** All Qualifying DY 13 UC providers eligible for payment paid.



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Contacting HHSC

- The PFD Hospitals email, PFD_Hospitals@hhsc.state.tx.us, is the contact email for all DSH/UC and application related questions and issues.
- HHSC will publish payment schedules and timelines, as well as pertinent information for hospital providers on our website at <https://pfd.hhs.texas.gov/pfd-supplemental-payments-information>
- Providers will be contacted by various HHSC staff members who are reviewing the hospital's DSH/UC application during the review period.
- HHSC encourages all providers to be enrolled with [GovDelivery subscription](#) for any communication outside of the application process.



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Significant Updates for 2024/DY 13

- Supplemental survey required for all providers to complete. The survey will collect additional information relating to the new condition of participation for other supplemental payment programs and whether hospitals have residents . It also collects OP data relating to sections 5.4 through 5.6 of the Hospital Data tab.
- The Regional Health Partnership (RHP) requirement has been removed based on TAC 355.8212 rule updates.
- Affiliation agreements are also no longer required for 1115 waiver programs.
- CHIRP adjustment appeal request template and process and procedure available for 2024/DY13 program year.

Requesting an Extension for Submitting the Application



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- Requests need to sent to PFD Hospitals mailbox at:
PFD_Hospitals@hhsc.state.tx.us
- 5:00 pm **Monday, November 20, 2023**
- Does not apply to SPC Appeals, only to application submissions
- 15-day extension as per TAC 355.8066.
- All hospitals requesting an extension must submit applications by **December 05, 2023.**



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UC Rural Definition

- (17) Rural hospital--A hospital enrolled as a Medicaid provider that:
 - (A) is located in a county with 68,750 or fewer persons according to most recent decennial census U.S. Census; or
 - (B) was designated by Medicare as a Critical Access Hospital (CAH) or a Sole Community Hospital (SCH) before October 1, 2021; or
 - (C) is designated by Medicare as a CAH, SCH, or Rural Referral Center (RRC); and is not located in a Metropolitan Statistical Area (MSA), as defined by the U.S. Office of Management and Budget; or
 - (D) meets all of the following:
 - (i) has 100 or fewer beds;
 - (ii) is designated by Medicare as a CAH, SCH, or an RRC; and
 - (iii) is located in an MSA.



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DSH Rural Definition

A hospital that is a rural hospital as defined in §355.8052 of this chapter:

- (32) Rural hospital--A hospital enrolled as a Medicaid provider that:
- (A) is located in a county with 68,750 or fewer persons according to the 2020 U.S. Census;
 - (B) is designated by Medicare as a Critical Access Hospital (CAH), a Sole Community Hospital (SCH), or a Rural Referral Center (RRC) that is not located in a Metropolitan Statistical Area (MSA), as defined by the U.S. Office of Management and Budget; or
 - (C) meets all of the following:
 - (i) has 100 or fewer beds;
 - (ii) is designated by Medicare as a CAH, a SCH, or a RRC; and
 - (iii) is located in an MSA.

Non-Urban Public Hospital



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- (34) Non-urban public hospital--A hospital other than a transferring public hospital that is:
 - (A) owned and operated by a governmental entity; or
 - (B) operated under a lease from a governmental entity in which the hospital and governmental entity are both located in the same county, and the hospital and governmental entity have both signed an attestation that they wish the hospital to be treated as a public hospital for all purposes under both this section and §355.8212 of this subchapter (relating to Waiver Payments to Hospitals for Uncompensated Charity Care).

Conditions of Participation



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- **DSH:** 9) Participation in all voluntary Medicaid programs. Beginning in Federal Fiscal Year (FFY) 2024, it will be required for all non-rural hospitals, except for state-owned hospitals, to enroll, participate in, and comply with requirements for all voluntary supplemental Medicaid or directed Medicaid programs for which the hospital is eligible, including all components of those programs, within the State of Texas to participate in DSH, unless:
 - (A) a hospital is not required to enroll, participate in, and comply with the requirements:
 - (i) of a program without multiple components if the hospital's estimated payment from the entire program is less than \$25,000; or
 - (ii) of a program's component for programs that have multiple components if the hospital's estimated payment from the program's component is less than \$25,000; and
 - (B) enrollment for the program concluded after the effective date of this requirement
- **UC:** (F) Beginning in demonstration year thirteen, all non-rural hospitals, except for state-owned hospitals, will be required to enroll, participate in, and comply with requirements for all voluntary supplemental Medicaid or directed Medicaid programs for which the hospital is eligible, including all components of those programs, within the State of Texas to participate in UC. This requirement does not apply to a program or component, as applicable, if:
 - (i) a hospital's estimated payment:
 - (I) is less than \$25,000 from the entire program for a program without multiple components; or
 - (II) is less than \$25,000 from a component for a program with multiple components; and
 - (ii) enrollment for the program concluded after the effective date of this requirement.

Conditions of Participation-DSH



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In accordance with §355.8065(e)(9), with the exception of state-owned and rural hospitals, all hospitals are required to participate if eligible in these voluntary supplemental and directed payment programs in order to participate in DSH.

Hospitals can request for an exemption if the estimated payment is less than \$25,000 for a program with a single component, or less than \$25,000 for a component for programs with multiple components.

1) CHIRP

- Enrollment: February of each year
- ACIA remains an optional component
- Not required for FFY 2024

2) GME

- only for eligible teaching state, public and private hospitals
- No enrollment
- HCRIS cost report data pulled Oct 1st of each year*
- Cost report data will be two years prior*

3) HARP

- Enrollment: November of each year

4) UC

- Enrollment: September of each year

Conditions of Participation-UC



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In accordance with §355.8212(c)(1)(F), with the exception of state-owned and rural hospitals, all hospitals are required to participate if eligible in these voluntary supplemental and directed payment programs in order to participate in UC.

Hospitals can request for an exemption if the estimated payment is less than \$25,000 for a program with a single component, or less than \$25,000 for a component for programs with multiple components.

1) CHIRP

- Enrollment: February of each year
- ACIA remains an optional component
- Not required for FFY 2024

2) GME

- only for eligible teaching state, public and private hospitals
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3) HARP

- Enrollment: November of each year

4) DSH

- Enrollment: September of each year



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UC Application Fee

- SB 2138
- Non-refundable UC Application Fee for Non-public providers
- Fixed amount, may change yearly
- For DY 13, the UC application fee for non-public providers is \$10,000
- Checks or money order will be accepted
- Payment due at time of submission
- Application submission period : **October 20- November 20,2023.**
- No payment - account receivable account created
- **All non-public providers who submit a UC application will be assessed the application fee**
- The application fee is applicable even if providers decide not to participant in the program at a later time



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Payment Voucher

 TEXAS
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Service Code: 529201545
(for Accounting purposes only)

CCN

Hospital Name

Hospital Address

City, State Zip Code

Fee Description: UC APP FEE

Total Amount Due: \$10,000.00

To pay via Check or Money Order, mail your payment to:

HHSC AR MC1470
PO BOX 149055
AUSTIN TX 78714-9055

Payment Overnight Address:
HHSC AR MC1470
4601 W GUADALUPE STREET
AUSTIN TX 78751

Instructions for sending payment:

- DO NOT SEND CASH!
- Total amount on the check/money order must match the amount on this voucher.
- Include this voucher with payment
- No receipt will be sent

- HHSC has attached a **UC Fee Voucher PDF** document, the hospital will need to fill out CCN, Hospital Name, Hospital Address, City, State and Zip Code.
- After filling the required fields **print this document and send it in with your check.**
- Checks **MUST** be written to **Texas Health and Human Service Commission.**
- Ensure that the payment voucher is sent in with the check



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HHSC FTP Site

- Providers need to submit a patient-level detail, in the template sent with your application, for the patients included in uninsured charity amounts reported in worksheet S-10. A copy of the provider's charity care policy in a .pdf or word document will also be required.
- Any supporting documentation with PHI must use the HHSC FTP or own secure server.
- Registration up to two users per hospital
- Provider can use their own secure server
- **15-day record retention period (Autodelete after the 15th day)**
- Applications can be submitted:
 - PFD_Hospitals@hhsc.state.tx.us
 - To HHSC using the FTP Site
 - Providers own secure server site
 - Please notify PFD Hospitals mailbox when you have submitted your files on the FTP site.

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- Certification – applies to both UC and DSH
- As of DY 10, a digital signature will be accepted. [Rate Analysis Digital Signature Policy | Provider Finance Department \(texas.gov\)](#)
- An example of an approved digital signature :

Provider Signature	
Provider printed name: John Smith	Date: 11/23/2015
 Digitally signed by John Smith DN: cn=John Smith, o=Nurses 123, ou, email=johnsmith@nurses123.com, c=US Date: 2015.11.23 21:14:51 -06'00'	
Provider Signature (stamped signatures not accepted)	

- GovDelivery Auto-Enrollment

GovDel Auto Enrollment	
By checking this box, I consent to the emails provided in this application being auto-enrolled in HHSC GovDelivery notifications for DSH & UC topics.	<input type="checkbox"/> <input type="checkbox"/>
	<input type="text" value="Please Select"/> <input type="text" value="Please Select"/> <input type="text" value="Yes"/> <input type="text" value="No"/>

- Notify HHSC if prepopulated applications has any change by emailing at: PFD_Hospitals@hhsc.state.tx.us

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- **Adjustments Summary (UC Only):** Program year costs
 - Schedule 1 – Adjustments related to Physicians and Mid-Level Physicians
 - Schedule 2 – Adjustments related to pharmacy costs
 - Schedule 3 – Adjustments related to uninsured charity care
- Can request adjusted cost and payment data from the data year.
- Accepted supported documentation are:
 - Updated uninsured charity detail
 - New charity policy
 - A new submitted app with the changes applied
 - General ledger
 - Policies and procedures
 - Third party documentation

Support for Schedule 1 Physician Costs



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- All physician and mid-level direct patient care costs claimed supported by: a time study, contracts, or invoices
- Contracted physicians may use contracts and invoices to support the direct patient care costs being claimed
- Hospitals who employ physicians should have time studies.
- Time studies/proxies are the only acceptable support for mid-level costs and will not be allowed for physician costs.
- HHSC will also accept the time studies submitted with the providers' FFY 2022 Medicare Cost Report. Job descriptions will NOT be allowed for mid-level providers, as mid-level providers must be supported by time studies or time proxies.
- The only exception is using worksheet B Part I Col 24 which is for non-reimbursement cost centers which required an attestation confirm these costs are 100% direct patient care.



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Schedule 1 Allowable Costs

- Must include all revenues associated with Schedule 1 costs
- Revenues are entered on line 102.00 (Excel line 117) of Schedule 1. Costs entered in Schedule 1 must have offsetting revenue.
- Or provide HHSC with evidence of no payments with the claimed costs.

-	-			- Hospital Charges	-	-	-	-	-
	Total Cost								
102.00	Less: Service & Other Revenues								
103.00	Net Cost								

In order for Schedule 1 costs to be allowed, providers MUST enter all revenues associated with costs claimed. If you do not have revenue for the costs you are claiming, please provide the cost center number and reason for the lack of revenue below.

Cost Center Number	Title of Supporting Documentation File OR Reason for Lack of Revenue in Cost Center

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- **Schedule 1 (UC Only):** Only Change is that providers can only claim the physician and mid-level costs related to uninsured charity care.
- This worksheet computes the costs related to direct patient care services provided by physicians and mid-level professionals to uninsured charity care patients.
- Allocation statistics for any costs claimed on the Schedule 1 worksheet will be applied to the uninsured charity charges reported on Schedule 3 worksheet.
- Schedule 1 can be overwritten if providers wish to use physician charges or different charges.



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Schedule 1 Support

- Time Study
- Time Proxies
- Contracts
 - Contract Requirements:
 - In instances where a physician or mid-level professional is able to provide a contract that scopes out the specific direct patient care being provided and that contains the same information provided by a time study, that contract may be used for reconciliation purposes.
 - Contracts must be in effect during the cost report period under reconciliation.
 - Contracts should be submitted in their entirety, including amendments.
 - Contracts with required administrative/provider component, or otherwise non-allowable activities will not be sufficient to support the direct patient care requirement unless the related cost or a percentage of time spent on those activities is scoped out (same information as time study), even if physician compensation is based on RVUs, patient encounters, or other direct patient care statistics.
 - Examples of duties that could trigger the need for time studies:
 - Medical director
 - Supervision
 - Training
 - Meetings
 - Utilization review
 - Participation in quality assurance programs
 - Research

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- **Schedule 2 - UC Only:** Computes the self-pay pharmacy costs related to prescription drugs provided by hospitals participating in the Texas Vendor Drug program.
- A provider must be enrolled in the Texas Vendor Drug Program to submit their self-pay pharmacy costs.
- For additional questions regarding Schedule 2 email the PFD Hospitals mailbox.

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- **Hospital Data:**
 - Except for the portion of the LPPF cost attributable to uninsured charity, this section is utilized for DSH SPC/Qualification
 - Providers who do not wish to participate in the DSH program can opt to not complete this worksheet.
 - HHSC encourages all providers who meet the two physician and trauma certification requirements to provide the DSH data in this worksheet regardless of your DSH qualification status in prior years.

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Hospital Data (cont.):

- Tax Revenue (5.4)
- Tax Revenue can only be filed by public hospitals, State Teaching and State IMDs.
- The industry standard for calculating Tax Allocation is typically
- $\left(\frac{\text{Inpatient Revenue}}{\text{Total Revenue}}\right)(\text{Total Tax Appropriation})$
- Other calculations will be accepted as well,
- Supporting documentation

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Hospital Data (cont.):

- Data for Low Income Utilization Rate (LIUR) calculation should be limited to inpatient and outpatient care, not inpatient charity care.
- Charity charges reported in sections 5.7 and 5.8 are only used for DSH qualification and *NOT* UC uninsured charity. These charges are defined in 1 TAC §355.8065 (b)(7):
 - Charity charges - Total amount of hospital charges for inpatient and outpatient services attributed to charity care in a DSH data year. These charges do not include bad debt charges, contractual allowances, or discounts given to other legally liable third-party payers
 - HHSC will check the sum of the amounts in 5.7 and 5.8 against S10 Line 20 Col 3 in the cost report
 - If the sum of these amounts exceeds the amount reported in S10 Line 20 Col 3 of the cost report, additional support must be provided

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Hospital Data (cont.):

- Organ acquisition costs complete in section 6.5 have been separated into uninsured, charity, and Medicaid costs in worksheet “D-4 Col 1&2 Ln 61, 66, 62”.
- Providers should only submit data in the highlight yellow sections.
- Providers must also identify any organs that are duplicated when reporting uninsured organs and uninsured charity organs.
- **Providers may NOT claim organ costs in the ancillary section of the Cost Report Collection worksheet.**

6.5 Hospitals with Transplant costs, please list total charges from W/S D-4, Part III. Summary of Costs and Charges

	Organ Acquisition Cost	Revenue from Organs Sold	Total Useable Organs (Count)	Medicaid Eligible Organs (Count)	Uninsured Eligible Organs (Count)	Charity Eligible Organ (Count)	Duplicate Organ (Count)
Organ Acquisition Cost Centers	Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61	Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 66	Cost Report Worksheet D-4, Pt. III, Col 2, Line 62	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note B)	From Paid Claims Data or Provider Logs (Note C)	From Paid Claims Data or Provider Logs (Note D)
Lung	-	-	-				
Kidney	-	-	-				
Liver	-	-	-				
Heart	-	-	-				
Pancreas	-	-	-				
Intestinal	-	-	-				
Islet	-	-	-				

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Hospital Data (cont.):

- Please enter any secondary non-billed payments, charges, and days in Section 6.6.
- Section 6.7 relates to the Local Provider Participation Fund (LPPF), which states that hospitals required to make a mandatory payment to a local jurisdiction that administers an LPPF may claim a portion of the mandatory payment as an allowable cost.
 - Only private hospitals pay into LPPFs, including private IMDs. If any other ownership type is included, HHSC will advise the provider, HHSC will not accept this and remove the amount.
 - **Only hospitals with a LPPF Jurisdiction can apply for this cost!**
 - HHSC has standardized the calculation.
 - In the LPPF Charges - Duplicate cell (L182).
 - The hospital must provide documentation in the form of tax statements
 - Hospitals who began incurring this cost after the data year may claim these costs for UC only in the form of a schedule 3 adjustment.

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Hospital Data 2: The only change is that HHSC split this portion of the tool into DSH Only, and UC Only Sections. Overall:

- DSH uninsured charges, payments, and days,
- UC uninsured charity charges, payments, and days,
- UC uninsured charity charges, payments, and days duplicated in DSH uninsured,
- Non-covered services charges, payments, and days (reported in the (S-10 Column 1)

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Hospital Data 2 – Sections 7 – (DSH Only) Providers will utilize this section for reporting uninsured charges, payments and days.

Section 7: Uninsured Charges & Payments (DSH) And DSH ONLY - Uninsured Charges & Payments

- of 21 and 64; and
- Facility fees associated with subproviders providing services to uninsured patients (e.g.; rehabilitation services)

		DSH Total Uninsured	
		Charges (\$)	IP Days
7.1	Inpatient Data		
7.2	Outpatient Data		

PAYMENTS (for Uninsured DSH Reporting): Report all payments received for patients discharged during the Data year, including payments received to date. Payments will not include insurance payments for covered patients as they are not considered uninsured. A payment received is any payment from an uninsured patient or from a third party on the patient's behalf (see Uninsured Definition at the top of Section 8). Certain state- and local-only payments are not considered payment for uninsured services (see Federal DSH Rule page 77813, Column 2, Comment 1).

		DSH Total Uninsured
		Payments (\$)
Payments Received for Discharged Patients		
7.5	Section 1011 Payments	
7.6	Allowable State and Federal Payments (see Federal DSH Rule, page 77817, Column 3, 1st response). Itemize in table below.	
7.7	Cash for uninsured liens and sold uninsured accounts	
7.8	Uninsured Inpatient Payments	
7.9	Uninsured Outpatient Payments	
Total		-

For subsection 7.6 above, please itemize the following details:

		DSH Total Uninsured
		Payments (\$)
Allowable State and Federal Payments Itemization:		
7.6.1	Maternal and Child Health Services (Title V of the Social Security Act)	
7.6.2	Family Planning (Title X of the Public Health Services Act)	
7.6.3	Ryan White (Ryan White HIV/AIDS Treatment Extension Act of 2009 and Comprehensive AIDS Resources Emergency Act)	
7.6.4		
Total State & Federal Funded Payments		-

Totals match

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Hospital Data 2 – Section 8 – (DSH Only) Providers will report uninsured charges, payments and days for patients with exhausted lifetime and annual insurance benefits.

Section 8: Uninsured Charges & Payments (Where Patients Exhausted Lifetime And Annual Insurance Benefits)

CMS revised the uninsured definition to add certain claims and costs to the uninsured calculation of the DSH hospital specific limit. Please complete this section as an addition to Section 8.

CHARGES: CMS expanded the uninsured definition used in DSH to include inpatient and outpatient hospital services for individuals who have no health insurance or other source of third party coverage during the data year. This includes charges for certain patients that have exhausted lifetime and annual insurance benefits. In addition, include hospital services provided to a patient with insurance where the insurance did not cover the service. Services must be Medicaid eligible.

Hospitals must continue to **exclude** the following charges for DSH Uninsured Data:

- Costs associated with bad debt, payer discounts, and unpaid coinsurance and deductibles;
- Services for inmates or other incarcerated individuals; and
- Services that would not be covered under the Texas Medicaid State Plan had the individual been Medicaid eligible.

		DSH Total Uninsured	
		Charges (\$)	IP Days
8.1	Charges for patients who had exhausted their lifetime or annual insurance coverage and received inpatient services		
8.2	Charges for patients who had exhausted their lifetime or annual insurance coverage and received outpatient services		
8.3	Charges for patients who had insurance that did not cover the inpatient hospital service		
8.4	Charges for patients who had insurance that did not cover the outpatient hospital service		

PAYMENTS: Hospitals must include any payment made by or on behalf of patient who has exhausted benefits or received a service that was not a covered benefit of the insurance the patient had for DSH Uninsured Data.

		DSH Total Uninsured Payments (\$)
8.5	Payments for patients who had exhausted their lifetime or annual insurance coverage and received inpatient services	
8.6	Payments for patients who had exhausted their lifetime or annual insurance coverage and received outpatient services	
8.7	Payments for patients who had insurance that did not cover the inpatient hospital service	
8.8	Payments for patients who had insurance that did not cover the outpatient hospital service	

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Hospital Data 2 – Section 9 – (UC Only) Providers will report:

- UC uninsured charity charges, payments, and days,
- Non-covered services charges, payments, and days (reported in the (S-10 Column 1),
- UC uninsured charity charges, payments, and days **duplicated in DSH uninsured.**

Section 9: Charity Charges & Payments (UC)									
UC ONLY - If not participating in UC, skip this section.									
							S-10 providers should break out the charges from non-covered services and report them in cells J96-97, and report the remaining uninsured charity charges in cells D96-97. The sum of these charges should be equal to or less than the total uninsured charity charges reported in w/s S-10.		
Only enter information into the green highlighted cells.	UC Charity Care Charges and Days S-10, Column 1, Line 20 (See Instructions for Non S-10 Providers; Both S-10 and non-S10 providers should NOT include non-covered services in these cells)		UC Charity Care Payments S-10, Column 1, Line 22 (See Instructions for Non S-10)	UC Uninsured Charity Charges and Days duplicated in DSH Uninsured (the shortfall resulting from this information will be subtracted from the DSH uninsured shortfall to calculate the DSH-		UC Uninsured Charity Payments duplicated in DSH Uninsured Payments	Charges and Days For Noncovered Services (reported in S-10 Column 1)		Payments for Noncovered Services (reported in S-10 Column 1)
	Charges (\$)	IP Days	Payments (\$)	Charges (\$)	IP Days	Payments (\$)	Charges (\$)	IP Days	Payments (\$)
9.1 Inpatient Data									
9.2 Outpatient Data									
							<u>\$0.00</u>		<u>\$0.00</u>

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Hospital Data 2: Reporting Uninsured Charity & Identifying Non-Covered Services

- HHSC has pre-populated the uninsured charity charges from S-10 col 1 line 20/22.
- Providers should also identify the IP days associated with all IP charges.
- Non-covered services **MUST NOT** be duplicated in the uninsured charity charges in cells D126-F127.
- The total of the uninsured charity/non-covered charges reported in D126, D127, J126, and J127 cannot exceed the total charges from worksheet S-10 populated in F130.

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Hospital Data 2 – Section 9 – (UC Only) Providers will report:

- UC uninsured charity charges, payments, and days **duplicated in DSH uninsured.**
- **Duplicated should cover FFY and Cost Report Period.**

• Providers participating in both DSH and UC must identify the UC uninsured charity charges, days, and payments that are duplicated in their DSH uninsured data, irrespective of the discrepancy between DSH being based on discharge date from 10/1 - 9/30 and UC being based on write-off date in the providers' cost report year. This means that if a UC uninsured charity claim is in the DSH uninsured data this year but not in the UC uninsured charity data this year, it should still be identified as a duplicate claim because it will eventually be included in UC. It is imperative that providers properly identify this data to avoid duplication of DSH and UC payments for the same cost, and thus a potential overpayment when DSH audits and UC reconciliations are performed. These DSH-only uninsured charges, payments, and days must be reported in cells G96 - I97.

S-10 providers should break out the charges from non-covered services and report them in cells J96-97, and report the remaining uninsured charity charges in cells D96-97. The sum of these charges should be equal to or less than the total uninsured charity charges reported in w/s S-10.

	UC Charity Care Charges and Days S-10, Column 1, Line 20 (See Instructions for Non S-10 Providers; Both S-10 and non-S10 providers should NOT include non-covered services in these cells)		UC Charity Care Payments S-10, Column 1, Line 22 (See Instructions for Non S-10 Providers)		UC Uninsured Charity Charges and Days duplicated in DSH Uninsured (the shortfall resulting from this information will be subtracted from the DSH uninsured shortfall to calculate the DSH-Only)		UC Uninsured Charity Payments duplicated in DSH Uninsured Payments		Charges and Days For Noncovered Services (reported in S-10 Column 1)		Payments for Noncovered Services (reported in S-10 Column 1)
	Charges (\$)	IP Days	Payments (\$)	Charges (\$)	IP Days	Payments (\$)	Charges (\$)	IP Days	Charges (\$)	IP Days	Payments (\$)
9.1 Inpatient Data											
9.2 Outpatient Data											
	<u>\$0.00</u>					<u>\$0.00</u>					
	Charges from Worksheet S-10:					Payments from Worksheet S-10:					



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S-10 Support:

- Both S-10 and Non-S10 providers must complete the Uninsured Charity Detail Template.
- Supporting documentation for all uninsured charity charges reported in the application must use the following naming convention.
(TPI_ProviderName_DY13 Charity Detail.xlsx)
- Charity IP Days = $\left(\frac{\text{Charity Charges}}{\text{Total Uninsured Charges}}\right)(\text{Total Days})$
- This template contains a calculation that uses the previously stated logic and will standardize the calculation of IP days for uninsured charity accounts that were partially written off.

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S-10 Support (cont.):

- Providers should, when possible, distinguish if the line item is uninsured charity or a non-covered service.
- Refer to the template for instructions on what is required and note this year.
- HHSC will only require PHI to be submitted in the patient detail for IMD's.
- Providers must submit a copy of their charity care and financial assistance policies.

Overview of the Hospital Application



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Medicare Cost Report Worksheet:

- HHSC has pre-populated all standard whole number cost centers.
- HHSC has done so as a means to shorten the amount of time needed to review applications and to expedite final payment processing.
- Providers will still need to enter any subscribed cost centers from their Medicare cost report that they wish to include.

Overview of the Hospital Application



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Medicare Cost Report Worksheet (cont.):

- Providers will notice that the per diems calculated in worksheet “D-1 Col 1 Ln 26” and the cost to charge ratios calculated in worksheet “C Part I Col 4”, are not using Column 9. Instead, the application is calculating the RCC’s using total charges from Worksheet “C Part I Col 8”, and total cost before Interns and Residents costs are removed from worksheet “B Part I Col 24”.
- Per diem calculations also utilize this methodology. HHSC was unable to pre-populate subscribed cost centers and has designated yellow cells for providers to enter the charges and costs for these lines. Do not insert lines in the Medicare Cost Report worksheet. If you need additional cost center lines, please contact HHSC.

Overview of the Hospital Application



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Medicare Cost Report Worksheet (cont.):

- HHSC is also allowing providers to add back the costs in excess of the RCE limits removed in worksheet “C Part I Col 4” for the purpose of calculating hospital cost to charge ratios. These costs are pre-populated in the yellow RCE columns in both the routine and ancillary cost centers by the applicable cost center line.
- HHSC has pre-populated the figures to calculate observation bed costs in the ancillary section of the Medicare Cost Report worksheet. This includes a separate per diem calculation and the removal of swing bed cost in the routine section.



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Additional Worksheets in the Application

- There are additional worksheets in the application that will assist HHSC in the calculation of DSH and UC for internal use only and are locked.
- These worksheets consist of all worksheets to the right of the “Medicare Cost Report”.
- With the exception of the green tabs “Medicaid Claims Data” and “404 Report Medicaid Claims Data” worksheet, which contains data that providers may appeal through TMHP.



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Schedule 3 – Uninsured Charity

- Please note that “Schedule 3” refers to the calculation of uninsured charity cost for the UC program, while “Schedule 4” refers to the calculation of the DSH SPC. Both schedules use the Medicare Cost Report worksheet and various data from other worksheets to calculate cost.
- The worksheets that comprise the calculations for Schedule 3 are labeled as follows. These are non-yellow worksheets included for informational purposes that providers do not need to complete, and are locked so that they cannot be edited:
 - **Sched3–Charity Costs** – Costs calculated in the “Cost Rept Charity cost” worksheet are summarized to calculate the uninsured charity shortfalls.
 - **Sched3–Cost Rept Charity** – Costs are calculated at the cost center level for uninsured charity and costs duplicated in DSH uninsured and UC uninsured charity based on the uninsured charity charges and days entered in the Hospital Data 2 worksheet.



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Schedule 4 – DSH State Pmt Cap

- **Sched 4 – DSH State Pmt Cap:** This worksheet uses provider reported data from the Hospital Data, and Schedule 2 worksheet, the “Medicaid Claims Data” worksheet, and HHSC’s pre-populated data in the “Sched 4-State Pmt Cap” worksheet to calculate multiple unadjusted DSH State Payment scenarios.
- HHSC adopted the State Payment Cap (SPC) (previously the interim Hospital Specific Limit) as of February 2020 (1 TAC §355.8066), which is the amount calculated in cell B30. Cells A31-A34 are solely for informational purposes. The other options present multiple DSH SPC scenarios based on modeling previously proposed by HHSC. The State Payment Cap includes all costs and payments for individuals with both Medicaid and other insurance or Medicare. The various State Payment Cap scenarios are summarized/calculated in cells A30-A34 of this tab.
- Providers can view the actual Medicaid and uninsured cost calculations in the “Sched 4 Cost Rept Cost Calc” and “Sched 4 Cost Rept UninsuredCosts” worksheets.
- For program periods beginning October 1, 2022, HHSC will determine the lesser of between the two payment ceilings (full-off set and the MACPAC methodologies). The lesser of the two payment ceilings will constitute the State Payment Cap for the DSH program described in §355.8065 of this division and in the UC program described in §355.8212 of this subchapter.



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Schedule 4 – DSH State Pmt Cap

State Payment Cap Scenarios	Unadjusted Medicaid Shortfall	Inflated State Payment Cap
With OI and Medicare Payments	\$ -	\$ -
Without OI and Medicare Payments	\$ -	\$ -
Without OI Payments	\$ -	\$ -
Medicaid-Only (MACPAC)	\$ -	\$ -
SB 7 Aggregate Approach	\$ -	\$ -



Schedule 4 – DSH State Pmt Cap

- Sched 4 Cost Rept Cost Calc worksheet** – This worksheet calculates the cost separately for Medicaid primary, other insurance, and Medicare based on the charges and days that were split into the same three categories on the “404 Report Medicaid Claims Data” worksheet. This split is necessary to be able to calculate the SB 7 and MACPAC SPCs.

Medicaid Cost of Care											
TestApp (TPI: 000000000)											
Cost Report Period: Waiting for a TPI - Waiting for a TPI											
Cost Report Status: Waiting for a TPI											
Days and Charges Data											
	FFS			MCO			OOS			Secondary Non-Billed	Secondary Non
	IP Days	IP Charges	OP Charges	IP Days	IP Charges	OP Charges	IP Days	IP Charges	OP Charges	IP Days	IP Charges
Medicaid	-	-	-	-	-	-	-	-	-	-	-
Medicare	-	-	-	-	-	-	-	-	-	-	-
Other Insurance	-	-	-	-	-	-	-	-	-	-	-
Total	-	-	-	-	-	-	-	-	-	-	-
THIS SECTION IS PER DIEM COSTS PER HOSPITAL DAYS AND PER DIEM											
Inpatient Days				FFS		FFS		FFS		FFS	
				1B		A*1B		2B		A*2B	
S-3 / B Part I	Description	Form S-3, Part I, Col 8 Days	Per Diems	Medicaid FFS Allocated Days	Medicaid FFS IP Routine Cost	Medicare FFS Allocated Days	Medicare FFS IP Routine Cost	Other Insurance FFS Allocated Days	Other Insurance FFS IP Routine Cost	Other Insurance FFS Allocated Days	Other Insurance FFS IP Routine Cost
1/30	HOSPITAL ADULTS AND PEDIATRICS	-	-	-	-	-	-	-	-	-	-
8/31	INTENSIVE CARE UNIT	-	-	-	-	-	-	-	-	-	-
9/32	CORONARY CARE UNIT	-	-	-	-	-	-	-	-	-	-
10/33	BURN INTENSIVE CARE UNIT	-	-	-	-	-	-	-	-	-	-
11/34	SURGICAL INTENSIVE CARE UNIT	-	-	-	-	-	-	-	-	-	-
12/35	OTHER SPECIAL CARE UNIT	-	-	-	-	-	-	-	-	-	-
13/43	NURSERY	-	-	-	-	-	-	-	-	-	-
16/40	SUBPROVIDER IPF	-	-	-	-	-	-	-	-	-	-
17/41	SUBPROVIDER IRF	-	-	-	-	-	-	-	-	-	-
18/42	SUBPROVIDER (OTHER)	-	-	-	-	-	-	-	-	-	-
-	-	-	-	-	-	-	-	-	-	-	-
-	SUBSCRIPTED COST CENTERS GO HERE	-	-	-	-	-	-	-	-	-	-
-	SUBSCRIPTED COST CENTERS GO HERE	-	-	-	-	-	-	-	-	-	-
-	-	-	-	-	-	-	-	-	-	-	-
-	-	-	-	-	-	-	-	-	-	-	-

404 Report Medicaid Claims Data Worksheet; Pre-Populated Medicaid Data



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- HHSC populated the green worksheet in the application titled "404 Report Medicaid Claims Data" with data populated at the detail level that providers see in the 404 reports requested from TMHP.
- The purpose of this worksheet is to provide hospitals the means to tie the pre-populated Medicaid data in their 2024 application to their 404 reports without having to sum various data points to tie to what HHSC populated.
- This worksheet summarizes the charges, days, and payments from the "Medicaid Claims Data" worksheet that have been broken out at a lower level to be able to calculate the SB 7 and MACPAC SPCs.
- Providers can identify which cells from the Medicaid Claims Data worksheet are summed to tie back to the fields found in the 404 reports in lines 7-12 of this worksheet. The adjustments historically found in this worksheet have been moved to the Medicaid Claims Data worksheet.

Medicaid Claims Data Worksheet;



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- HHSC has broken out the Medicaid claims data historically populated in this worksheet at a lower level to be able to calculate separate cost for Medicaid primary, other insurance, and Medicare so that the SB 7 and MACPAC SPCs can be calculated in the event they are ever used, or if more modeling is needed.
- This data is summarized back to the normal 404 level so that providers can tie their 404 reports from Medicaid in the “404 Report Medicaid Claims Data” worksheet.
- Providers will find all adjustments that HHSC has made to the Medicaid data in this worksheet.

HHSC Supplement Document



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National Provider Identifier (NPI):	
Texas Provider Identifier (TPI):	
Demonstration Year (DY): 13	
Program Year (PY): 2024 (10/1/2023 - 9/30/2024)	
Federal Fiscal Year (FFY): 2024 (10/1/2023 - 9/30/2024)	
Data Year: 2022 (10/1/2021- 9/30/2022)	
Calendar Year: 2023 (01/01/2023 - 12/31/2023)	
Does the hospital have a residency program?*	Please Select
*According to your cost report S-3 Part 1 Col 9 Line 27	
Program Eligibility	
Is your hospital eligible to participate in CHIRP SFY 2024?*	Please Select
Was your hospital able to participate in CHIRP SFY 2024?*	Please Select
Is your hospital eligible to participate in HARP PY 2024?	Please Select
Does your hospital intend to participate in HARP PY 2024?	Please Select

5.4 Tax Revenue for outpatient charity care received by the hospital for outpatient services		Outpatient
5.5 Identify locally-funded (City & County) programs and the amount of funds used for outpatient care. Group program names under \$10,000 should be included on one line.		Outpatient
5.5.1		
5.5.2		
5.5.3		
5.5.4		
5.5.5		
5.5.6		
5.5.7		
5.5.8		
5.5.9		
5.5.10		
5.5.11		
5.5.12		
5.5.13		
5.5.14		
5.5.15		
5.5.16		
Total		0
5.6 Identify state-only funded programs and amounts used for outpatient care. These amounts will likely differ from other state surveys.		Outpatient
5.6.1		
5.6.2		
5.6.3		
5.6.4		
5.6.5		
5.6.6		
5.6.7		
5.6.8		
5.6.9		
5.6.10		

Chirp Adjustment Appeal Process

- Providers can submit a CHIRP adjustment appeal by completing and submitting a CHIRP adjustment appeal template at the time of DSH/UC application submission. The completed template must be submitted before the DSH/UC application submission deadline in order for appeal to be reviewed.
- All three tabs must be completed: Hospital Information, Appeal Summary, and MMIS Data Template
- Hospital Information Tab
- Fill out all of the sections in yellow.



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CHIRP Adjustment Appeal for DSH FFY 2024 & UC DY 13	
Please complete all sections in yellow. See instructions tab for additional information.	
Hospital Name:	
DBA (Doing Business As):	
Medicare Provider No. (CCN):	
National Provider Identifier (NPI):	
Texas Provider Identifier (TPI):	
CHIRP Class:	Select one
SDA:	Select one

Chirp Adjustment Appeal Process

- Appeal Summary –
- The original CHIRP adjustment values will come from CHIRP adjustment calculation for FFY 2024
- All values provided in the MMIS summary table must be supported by actual line item MMIS data
- All claims listed on the Appeal Template must be adjudicated within the CHIRP data year of 10/01/21-09/30/22.
- Appeals are limited to prior period data used in the CHIRP adjustment calculation.
- Appeal and support documents should be submitted with the application packet by the submission deadline.



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Chirp Adjustment Appeal Process

- MMIS Data –
 - All values will need to be claim level detail to support the adjustment.
 - All CHIRP non-eligible exclusion claims must be marked for CHIRP exclusion
 - IMDs are required to provide client date of birth information for each claim. Clients in the age exclusion group need to be indicated as a CHIRP exclusion claim
 - All CHIRP adjustment appeals must be limited to adjudicated claims in the data year for DSH and UC. No appeals of the CHIRP SFY 2024 payment estimates will be accepted.



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Adjustments to Medicaid Data

- **MCO Days Adjustment** - Research was done to determine where the Quantity Billed (data element that is used to calculate days) on a MCO Encounter seemed excessively high. These MCO Encounters were then compared to the total calculated Dates of Service (From Date of Service and To Date of Service) for the related MCO Encounter.
- If the Quantity Billed exceeded the total calculated Dates of Service for the MCO Encounter, then an adjustment was made to align the Quantity Billed (days) with the Dates of Service for that encounter.
- **FFS Day Adjustment** - Research was done to determine where the Quantity Billed (data element that is used to calculate days) on a FFS Medicare cross-over claim seemed excessively high.
- These FFS Medicare claims were then compared to the total calculated Dates of Service (From Date of Service and To Date of Service) for the related FFS Medicare claim.
- If the Quantity Billed exceeded the total calculated Dates of Service for the FFS Medicare, then an adjustment was made to align the Quantity Billed (days) with the Dates of Service for that FFS Medicare claim.



Adjustments to Medicaid Data, Con't.

- **FFS PPE Adjustment** – Potentially Preventable Events - Flat-rate reimbursement adjustments were made on payments to all inpatient hospital claims based on the individual hospital's rate of PPEs for state fiscal year 2021.
- Adjustments were then made to the affected FFS and MCO claims in order to determine what these claims would have been paid without the PPE adjustment. This amount was then added back into the related totals to reflect what these claims would have been paid without the PPE adjustment. These adjustments were applied to both FFS and MCO IP payments.

Adjustments to Medicaid Data, Con't



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- **Hospital Augmented Reimbursement Program (HARP) adjustment:** HHSC will include a payment adjustment for HARP federal fiscal year 2024 payments, for both the non-state government owned (NSGO) and private classes, at a later date. Because the enrollment period, calculation, and eventual payment will not occur until after the DSH/UC applications are due back to HHSC, this adjustment will only be applied to the final DSH/UC applications.
- **CHIRP Adjustment-**HHSC has calculated CHIRP adjustments using the projected payment amounts for CHIRP state fiscal year 2024 (SFY24). The estimated payment amounts were based on actuarially-forecasted MCO encounters at the time the program calculation was built. Also, because 11 months of CHIRP PGY5 and 1 month of CHIRP state fiscal year 2023 (SFY23) estimated payment amounts are included in the 2022 MCO payments, HHSC has attempted to adjust for this when calculating CHIRP adjustments.



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Adjustments to Medicaid Data, Con't.

- **Rural Hospital Inpatient Standard Dollar Amount Adjustment** –
 - During the 86th Legislative Session, HB 1 (General Appropriations Act) Riders 11 and 28 were passed. The riders appropriated additional funds for rural hospitals. The SDA adjustments have been calculated to reflect the additional funding that will be paid out in SFY 2021.
 - The calculation of the Rural SDA Adjustment for Fee for Service inpatient claims – Total payments (excluding delivery DRGs claims) for discharges that occurred in SFY 2021 were increased by the percentage increase in the SDA rate from 2021 SDA to 2023. The difference in the original payment and the calculated payment is the adjustment amount.
 - The calculation of the Rural SDA Delivery Adjustment for Fee for Service inpatient claims – Total payments for delivery DRGs were increased by the percentage change in the SDA rate from 2021 to 2023. The difference in the original payment and the calculated payment is the adjustment amount. Adjustments were made separately for the SDA + Delivery add-on and the non-delivery claims.



Adjustments to Medicaid Data, Con't.

- **Rural Hospital Inpatient Standard Dollar Amount Adjustment con't.-**
- The calculation of the adjustment for Rural hospital MCO inpatient encounters – Total payments for CHIRP related discharges that occurred in SFY 2021 were reduced by the CHIRP payment percentages by applicable quarters. The resulting payments plus any non-CHIRP related encounter payments were increased by the percentage increase in the SDA rate from SFY 2021 to SFY 2023. The difference in the original payment and the calculated payment is the adjustment amount.
- The calculation of the adjustment for Rural hospital MCO inpatient delivery encounters – Total payments for CHIRP related discharges that occurred in SFY 2022 delivery services were reduced by the CHIRP payment percentages by applicable quarters. The resulting payments plus any non-UHRIP related encounter payments were increased by the percentage increase in the SDA rate from SFY 2021 to SFY 2023 plus the SDA Delivery Add-on. The difference in the original payment and the calculated payment is the adjustment amount.
- **HARP, FFS Day and GME** adjustment will be coming later in the application review process.

State Payment Cap Appeal Process Overview



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- While the appeal process now only pertains to Medicaid data used in the DSH SPC, providers should still review and appeal the Medicaid data, as it will be used in future DSH examination and UC reconciliations.
- Providers have 30 calendar days from receiving their application to appeal the pre-populated data in the green “404 Report Medicaid Claims Data” worksheet of the application. Providers must follow the guidelines for requesting a review of their Medicaid data that is outlined in 1 TAC § 355.8066 (f)(2).
- The request must allege the specific data omissions or errors that, if corrected, would result in a more accurate SPC.
- If you believe that the data in the green “404 Report Medicaid Claims Data” worksheet contains errors, request the claims detail for your hospital by sending an email to DSH_Appeals@tmhp.com.
- If you decide to appeal the data, you must submit the “2024 SPC Claims Appeal Template” that was attached with your application to TMHP through the TMHP DSH Provider Portal database via secure file transfer protocol. Provider Portal database via secure file transfer protocol.

State Payment Cap Appeal Process Overview



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- Providers must notify TMHP that the file was successfully transmitted by sending an email to DSH.Appeals@tmhp.com and must also copy the PFD hospital mailbox (pfd_hospitals@hhsc.state.tx.us) on their appeal submission.
- While claims denied for late filing are only included in the final hospital specific limit in DSH or UC, HHSC is requesting any concerns with this data be submitted in the formal appeal template. If appealing denied FFS claims, you must include the exception reason on the INRR403B report, or the appeal will be denied.
- Do not wait until the DSH examination or UC reconciliation to attempt to submit an informal claim or encounter appeal for DSH/UC 2022 data.
- Informal MMIS data appeals during the UC reconciliation and DSH examination are limited to compilation errors made by the auditors. Other data issues (e.g., adjudication errors by TMHP or MCOs, omitted claims or encounters, charge/payment amount discrepancies, billing errors by the hospital already appealed to HHSC, etc.) should have been considered and resolved during HHSC's formal data appeal processes for the program year 2024.

State Payment Cap Appeal Process Overview



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- Denied encounters are not included in the interim state payment cap or final hospital specific limit in DSH or UC. If an encounter is denied, it should be addressed directly with MCO and hospital, not with HHSC or TMHP. HHSC is requiring that all appeals must be submitted to TMHP by **MONDAY, November 20, 2023, by 5:00 pm.**
- All claims/encounters listed on the Appeal Template must be adjudicated within the SPC data year of **10/1/2021-9/30/2022.**
- Please note that a hospital submitting a request for review of data is not excused from submitting its completed application by **October 20-November 20, 2023, by 5pm** even if HHSC has not yet notified the hospital of the results of the review, unless the hospital has been granted an extension by HHSC.
- No extensions will be granted for submitting SPC appeals.
- Please confirm with TMHP mailbox that your request has been submitted.

State Payment Cap Appeal Template



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- Please ensure that all fields are complete in the State Payment Cap Appeal Template for all claims being appealed. This includes selecting a specific reason that you believe the appeal should be included or excluded from the Medicaid claims data.
 - If the PCN and the ICN are not a valid combination, they will be rejected, and no further review will be performed.
 - Valid PCN
 - No more than 9 digits
 - PCN starting with an Alpha character or the number 8, are not a valid PCN for Medicaid UC
 - Valid FFS and ENC ICNs
 - 24 digit claim specific Medicaid ICN format = PPP/CCC/MMM/CCYY/JJJ/BBBBB/SSS (don't include forward slash)
 - No set format for encounter ICNS, but must match to related R&S



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DSH/UC Provider Portal - TMHP

PLEASE DO NOT CONFUSE THE TMHP PORTAL WITH HHSC'S PORTAL; PROVIDERS MUST USE TMHP'S PORTAL TO SUBMIT SPC APPEAL TEMPLATES

As of July 2016, Texas Medicaid & Healthcare Partnership (TMHP) implemented a methodology and website (Workspaces) to access Provider DSH/UC data and to submit appeals -

<https://workspaces.tmhp.com>

- Instructions to access the TMHP portal was sent to providers
- The TMHP Provider DSH Portal provides a secure method for Trading Partners and State Agencies to exchange interface files, memorandums and reports.
- Only users with a secure/encrypted protocol can connect to the new site
- All reports will be available in .txt format. HHSC has provided instructions for converting the reports to Excel spreadsheets on the email sent to you containing your application



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DSH/UC Provider Portal - TMHP

SFTP Providers users must re-register with TMHP to create a user account to gain access to the new Workspaces site.

- Prior to the creation of a user account, all users must attest that they will comply with the security procedures.
- To comply, all users must sign a user agreement attestation form.
- Your business email address will be used as the username for your user account.
- The User Agreement Attestation form and the instructions for filling out, and submitting the form are in the TMHP Provider DSH Portal User Guide.
- The TMHP Provider DSH Portal User Guide document was sent with your application.
- Please email TMHP at DSH_Admin@tmhp.com for any additional questions regarding portal access.



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Submitting the Application to HHSC

When submitting the application to HHSC, providers **MUST** submit the application and all supporting documentation using the following naming conventions, which uses an underscore for spaces. If the facility is part of a system, please include the specific location of the hospital in the naming convention.

- TPI_ProviderName_NameOfDocument.

For example:

123456789_AustinHospital_CostReport

123456789_AustinHospital_Certification

123456789_AustinHospital_App

123456789_AustinHospital_DY13 Charity Detail



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Submitting the Application to HHSC

Providers should submit the application and the following supporting documentations:

- Signed Certification as a PDF document. The certification **MUST** have an original, or digital, signature by the hospital's CEO or CFO and be submitted with the application.
- Single cost report pages or a full, bookmarked cost report to support any changes or additions to the pre-populated HCRIS data.
- Support for Medicaid/Uninsured organ counts from the providers' general ledger.
- S-10 Uninsured Charity care detail support in HHSC's template, and a copy of the hospital's charity care policy in a pdf or Word document.
- If providers complete Schedule 1 of the application, they must submit a time study (and a summary), proxies, or contracts to support these costs are limited to physician and/or mid-level direct patient care. Providers should also include support for payments offsetting Schedule 1 costs, or evidence that no payments were received for the costs being claimed.

Submitting the Application to HHSC



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Providers should submit the application and the following supporting documentations:

- Support for any tax appropriation for inpatients and outpatients entered in the “Hospital Data” worksheet.
- Support for any adjustments in the “Adjustment Summary” worksheet from the hospital’s general ledger or other valid source. The supporting documentation should be limited to the numbers and calculations used to calculate the adjustment entered in the “Adjustments Summary” worksheet. Adjustments without supporting documentation will not be accepted.

All these items should be submitted through HHSC’s FTP site, or through the providers’ own FTP site, and a notification email to inform HHSC that the submission was uploaded to the FTP site should be sent to the PFD Hospital Mailbox.



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Corresponding with HHSC

- Questions regarding DSH payment amounts (not calculations) need to be sent to: DSHPayments@hhs.Texas.gov ; please include the facility's TPI number, facility's name, and point of contact's phone number
- Questions regarding **UC payments** or **UC affiliations** need to be sent to: [PFD UC Payments@hhs.texas.gov](mailto:PFD_UC_Payments@hhs.texas.gov), please include the facility's TPI number, facility's name, and point of contact's phone number
- SPC Appeal [DSH Appeals@tmhp.com](mailto:DSH_Appeals@tmhp.com), and TMHP portal questions need to be sent to: dsh_admin@tmhp.com
- All DSH and UC application and payment-related questions should be sent to [PFD Hospitals@hhsc.state.tx.us](mailto:PFD_Hospitals@hhsc.state.tx.us).



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Q&A

- If you have a question, you can type out your question in the message box, or you can raise your hand in the GoToWebinar task bar. Please keep the hand raised until called on to ask a question. We will also attempt to answer questions that are sent via the messaging feature as well.