Attachment H
UC Claiming Protocol and Application
Part 1: UC Claiming Protocol for Hospitals and Physician Groups

OVERVIEW

The intent of the Texas Medicaid Waiver Application ("UC Application") is to provide a simplified way to subsidize the costs incurred by hospitals, physicians and mid-level professionals for patient care services (as further defined below) provided to Medicaid and Uninsured patients that are not reimbursed through the claims adjudication process or by other supplemental payments. All UC payments to providers and all expenditures described as UC permissible expenditures must not exceed the cost of services provided to Medicaid and Uninsured patients as defined and discussed in this protocol. These unreimbursed Medicaid and Uninsured costs are determined based on one of two UC tools depending on the type of entity providing the service. These tools have been approved by the Centers for Medicare and Medicaid Services (CMS). To the extent that there are UC expenditures a hospital provider wants to make against the UC cost limit, and the methodology for capturing such expenditures is not stated in this protocol, the expenditures must be approved by CMS prior to the submission of the reconciliation for the applicable period for the expenditures.

The Medicaid coverage limitations under Section 1905(a) of the Act, which exclude coverage for patients in an institution for mental diseases (IMD) who are under age 65, except for coverage of inpatient psychiatric hospital services for individuals under age 21, are applicable.

The Texas Hospital Uncompensated Care tool ("TXHUC") will be utilized by hospitals to determine their unreimbursed costs for Medicaid and Uninsured patients for physicians' and mid-level professionals' direct patient care services where the hospital incurs these costs. In addition, if the hospital has unreimbursed hospital costs for services provided to Medicaid and Uninsured patients that were not paid via the claims adjudication process or thru the Medicaid Disproportionate Share (DSH) pool, these costs can be included in the TXHUC application. Also, for some hospitals meeting the criteria, unreimbursed pharmacy costs for take home drugs provided by the hospital to Medicaid and Uninsured patients will be included in the TXHUC application.

The Texas Physicians Uncompensated Care tool ("TXPUC") will be utilized by physician and/or mid-level professional entities that provide direct patient care physician and/or mid-level professional services to Medicaid and Uninsured patients in a hospital setting and the professional entity is not reimbursed under a contractual or employment relationship by the hospital for these services. The professional entity may also include in its TXPUC application the costs related to direct patient care services provided to Medicaid and Uninsured patients in a non-hospital setting. Only physician entities that had previously received payments under the Texas Medicaid Physician UPL (Upper Payment Limit) program and their successor organizations are eligible to submit a TXPUC application under the 1115 Waiver program.

The costs and other data included in the initial UC application should be representative of the fiscal period from October 1, 2009 through September 30, 2010. The UC application should be submitted to the Texas Health and Human Services Commission (HHSC) by the deadline specified by HHSC on its website at http://www.hhsc.state.tx.us/rad/hospital-svcs/1115-waiver.shtml. Applications for future fiscal periods which will cover the period from October 1 through September 30 of the applicable years will be due to HHSC by the deadline specified by HHSC. For hospitals, due to the five (5) month time period for the completion of the Medicare cost report which serves as the basis for the costs to be reported on the UC application, some entities will not have completed their cost report prior to the deadline for the submission of their UC application. In these situations, the hospital should submit a full 12 months of data

on the UC application based on the most recently completed Medicare cost reporting period that includes a minimum of twelve (12) months. It should be noted that when HHSC completes the reconciliation process, HHSC will utilize the hospital's actual data reported on their respective UC applications, weighted accordingly, to determine the hospital's final UC Pool distribution. This should not be an issue for physician and mid-level professional organizations since their financial data should be available immediately following the end of their respective fiscal years.

All costs and other data reported in the UC Application are subject to the Medicare regulations and Program instructions. The entity submitting the UC Application must maintain adequate supporting documentation for all information included in the UC Application in accordance with the Medicare program's data retention policies. The entity must submit the supporting documentation upon request from HHSC.

For purposes of the UC Application, a mid-level professional is defined as:

- Certified Registered Nurse Anesthetist (CRNA)
- Nurse Practitioner
- Physician Assistant
- Dentist
- Certified Nurse Midwife
- Clinical Social Worker
- Clinical Psychologist
- Optometrist

For purposes of the UC Application, a visit is defined as:

A face-to-face encounter between a patient and a physician and/or mid-level professional. Multiple encounters with the same physician and/or mid-level professional that take place on the same day and at a single location for the same diagnosis constitute a single visit. More than one visit may be counted on the same day (which may be at a different location) in either of the following situations:

a) When the patient, after the first visit, suffers illness or injury requiring another diagnosis or treatment, two visits may be counted.
b) When the patient is seen by a dentist and sees a physician and/or mid-level professional, two visits may be counted.

Texas Hospital Uncompensated Care Tool (TXHUC)

The TXHUC is comprised of a certification page, 4 primary schedules (a Summary Schedule and Schedules 1, 2 & 3) and various schedules. Schedules 1, 2 and 3 determine the hospital's unreimbursed costs for services provided to Medicaid and Uninsured patients related to physician and/or mid-level professional direct patient care costs, pharmacy costs, and DSH hospital costs, respectively. The supporting schedules are the schedules hospitals are required to submit to HHSC when applying for the Medicaid DSH program. Each of these schedules along with instructions for the completion of the schedule is detailed below.

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Certification

The certification page must be signed and dated by an officer or administrator of the provider. An officer is defined as a member of the provider's senior management such as the chief executive officer, chief financial officer, chief operating officer, etc. The certification must contain an original signature and not a copy or electronic signature. If the TXHUC is an initial submission, it should be so indicated in the appropriate box on the certification page.

Upon receipt of a final and/or amended final Medicare cost report, the provider is required to submit a "final" TXHUC based on the costs and other data contained in the final cost report. This final TXHUC will be utilized by HHSC to perform a final reconciliation of the actual costs for the period and the cost utilized to determine the provider's distribution from the UC Pool for that period. If the TXHUC submission is a final submission, it should be so indicated in the appropriate box on the certification page.

Upon the termination of the 1115 Waiver, providers will be required to submit actual cost data in the prescribed format of the TXHUC for a minimum of two years for purposes of reconciling the UC Pool payments for the last two years of the Waiver with the provider's actual costs incurred for those fiscal periods

Summary Schedule

Column 1 - Summarizes the Medicaid and Uninsured costs determined on Schedules 1, 2 & 3. These amounts will flow automatically from the respective schedules and no input is required.

Column 2 – The initial distribution of the Uncompensated Care Pool ("UC Pool") for the fiscal period 10/1/2011 – 9/30/2012 will be based on the costs for the period from 10/1/2009 – 9/30/2010 as computed on Schedules 1, 2 & 3. If the provider knows these costs are not representative of their actual costs for the period from 10/1/2011 – 9/30/2012, due to changes in their contractual arrangements or other operational or economic issues, the provider can make an adjustment to these costs. The provider is required to maintain supporting documentation to support their adjustment amount and make this information available upon request from HHSC and/or CMS.
Column 3 – Represents the net Medicaid and Uninsured costs after any adjustments and is determined by summing the amounts in Columns 1 & 2. The net cost amount will be utilized to determine the provider's distribution from the UC Pool.

Schedule 1

The schedule computes the costs related to direct patient care services provided by physicians and mid-level professionals to Medicaid and Uninsured patients. To be included in the schedule, these costs must be recorded on the hospital's accounting records and reported on the hospital's Medicare cost report, Worksheet A, Columns 1 and/or 2.

The source for these costs and other data will be the hospital's Medicare cost report(s) that span the period from October 1 through September 30 two years prior to the demonstration year for which UC payments are being determined. If the hospital's cost reporting period is other than October 1through

September 30, it will be necessary to pro-rate the costs and other data from the applicable cost reports that span this period.

Column 1 - The direct patient care physician and/or mid-level professional costs are identified from the Medicare cost report. These professional costs are:

1. Limited to allowable and auditable physician and/or mid-level professional compensations that has been incurred by the hospital;
2. Physician's services to individual patients identified as professional component costs on Worksheet A-8-2, Column 4 of the cost report(s);
3. Or, for contracted physicians and/or mid-level professionals only, Worksheet A-8, if the physician and/or mid-level professional compensation cost is not reported by the hospital on Worksheet A-8-2 because the physicians are contracted solely for direct patient care activities (i.e., no administrative, teaching, research, or any other provider component or non-patient care activities); and
4. Removed from hospital costs on Worksheet A-8 / A-8-2

If the professional physicians' costs on Worksheet A-8-2, Column 4 include Medicare Part A costs (e.g. departmental administration, hospital committee activities, etc.) that were reported as professional component due to lack of a physicians' time study(s) to allocate the costs between professional and provider component and/or application of the Reasonable Compensation Equivalents (RCE) , these costs must be excluded from the physicians' costs related to direct patient care professional services and cannot be included for UC reimbursement purposes unless the following conditions are met:

(1) The costs must be allocated between direct patient care (Medicare Part B) and reimbursable Medicare Part A activities. The costs associated with Medicare Part A activities must be subjected to the Medicare RCEs. If the hospital does not have adequate time studies for the application of the RCEs, then the hospital must obtain a proxy, signed and dated by the physician that estimates the amount of time spent on allowable Medicare Part A activities, teaching of interns & residents and medical students, research and direct patient care for the period the costs were incurred. The proxy should account for 100% of the physicians' time related to the costs incurred by the hospital. If the costs are for a group of physicians, each physician in the group must complete a proxy.
(2) For a physician the hospital can elect to apply the RCE limit on an individual physician basis or in the aggregate.
(3) The hospital must allocate the physicians' costs based on the physicians' proxy and apply the applicable RCE limits to the Medicare Part A non-teaching physicians'. The hospital must maintain auditable documentation of the determination of the allowable Part A non-teaching physician.
(4) For cost reporting periods beginning on or after 10-1-2012, the hospital is expected to obtain adequate and auditable time studies from each physician and/or mid-level professional providing Medicare Part A services to the hospital for the proper application of the RCEs via the Medicare 2552 cost report. The physician and/or

mid-level professional time study forms to be used are located on the Texas Health and Human Services Commission website. Time studies should be completed for a two (2) week period once per quarter during the fiscal year. Ideally, the time study period will not be the same two weeks in any 2 given quarters. Medicare Part A physician and/or mid-level professional costs will not be allowed to be included in the UC tool for cost reporting periods beginning on or after 10-1-2012.

Physician Part A costs in excess of the RCE limits cannot be included in Column 1. Physician costs related to direct patient care and physician Part A costs not in excess of the RCE limits should be reported on the respective line in Column 1 for cost reporting periods ending on or prior to 9-30-2012. For cost reporting periods beginning on or after 10-1-2012, Physician Part A costs cannot be included in Column 1.The physicians' costs should be reported in the cost center in which the expenses were reported on Worksheet A, Column 3 of the Medicare cost report.

Hospital costs for mid-level professional practitioner services that have been identified and removed from hospital costs on the Medicare cost report are to be included. Typically these costs are comprised of salaries and direct fringe benefits (payroll taxes, vacation and sick pay, health and life insurance, etc.), contract fees and professional liability insurance. The mid-level professional practitioner types to be included are:

(1) Certified Registered Nurse Anesthetists
(2) Nurse Practitioners
(3) Physician Assistants
(4) Dentists
(5) Certified Nurse Midwives
(6) Clinical Social Workers
(7) Clinical Psychologists
(8) Optometrists

To the extent these mid-level practitioners' professional compensation costs are not included in Worksheet A-8-2, Column 4, but are removed from hospital costs through an A-8 adjustment on the Medicare cost report, these costs may be recognized if the mid-level professional practitioners are Medicaid-qualified practitioners for whom the services are billable under Medicare separate from hospital services.

If the physician and/or mid-level practitioner costs are reported in a non-reimbursable cost center on the hospital's Medicare cost report, Worksheet A, these costs can be included in Column 1. The costs to be included would be the costs from Worksheet B Part I, the last column for the applicable line(s).

Hospitals may include physician and/or mid-level professional support staff compensation, data processing, and patient accounting costs as physician and/or mid-level professional-related costs to the extent that:

1. These costs are removed from hospital inpatient and outpatient costs because they have been specifically identified as costs related to physician and/or mid-level professional services;
2. They are directly identified on W/S A-8 as adjustments to hospital costs;
3. They are otherwise allowable and auditable provider costs; and
4. They are further adjusted for any non-patient-care activities such as research based on the physician and/or mid-level professional time studies.

If these costs are removed as A-8 adjustments to the hospital's general service cost centers, these costs should be reported on the General Services line (line 1) in Column 1.

If the hospital has costs for physicians and one or more types of mid-level professional for a given cost center, the costs can be combined and the total reported in Column 1 provided the same allocation statistic will be utilized to apportion the costs to Medicaid and Uninsured. If the hospital elects to utilize different allocation statistics to apportion the physician and/or any type of mid-level professional costs for a given cost center the cost center can be subscripted.

Column 1a – The recommended apportionment statistic for physician and/or mid-level professional costs is total billed professional charges by cost center. If a hospital does not maintain professional charges by payer type separately in its patient accounting system, then the professional costs can be apportioned based on total billed hospital departmental charges. Total billed hospital departmental charges by cost center are identified from the hospital's applicable Medicare cost report(s).

If professional charges related to the physician and/or mid-level professional services whose costs are reported in Column 1are utilized as the apportionment statistic, the professional charges must be from the same corresponding time period as the costs. The hospital must maintain adequate and auditable documentation to support the statistics reported in Column 1a.

If the hospital reports costs on the General Services line (Line 1) in Column 1, the recommended allocation statistic reported in Column 1a would be the aggregate total departmental charges (professional or hospital
department, based on the apportionment statistic for the specific cost centers) for all cost centers.

Column 1b – The allocation basis the hospital elects to utilize to apportion the costs from Column 1 should be identified for each cost center. The approved allocation bases are total departmental professional charges if available. Otherwise departmental hospital charges may be utilized.

Column 2 - A cost to charge ratio (CCR) for each cost center is calculated by dividing the total costs for each cost center reported in Column 1 by the total allocation statistic for each cost center reported in Column 1a. If additional lines are added to Schedule 1, it will be necessary to copy the formula used to compute the CCR for the additional line(s).

Columns 3a & 3b – The applicable allocation statistics related to the physician and/or mid-level professional services provided to Medicaid Fee-For Service (FFS) patients are reported in Columns 3a and 3b based on the hospital's elected allocation basis reported in Column 1b. The allocation statistics applicable to Medicaid FFS inpatient services are reported in Column 3a and allocation statistics

applicable to Medicaid FFS outpatient services are reported in Column 3b. The Medicaid FFS inpatient and outpatient statistics should be from the hospital's internal records and for the same fiscal period as the costs reported in Column 1 and total allocation statistics reported in Column 1a. If the hospital provided services to out-of-state Medicaid FFS patients, the charges related to those services should be included in Columns 3a and 3b as applicable.

Columns 3c & 3d – The Medicaid FFS inpatient and outpatient physician and/or mid-level professional costs are computed based on the CCR reported in Column 2 multiplied by the Medicaid FFS inpatient and outpatient allocation statistics reported in Columns 3a and 3b, respectively. If additional lines are added to Schedule 1, it will be necessary to copy the formula used to compute the Medicaid FFS inpatient and outpatient costs for the additional line(s).

Columns 4a & 4b - The applicable allocation statistics related to the physician and/or mid-level professional services provided to Medicaid Managed Care (HMO) patients are reported in Columns 4a and 4b based on the hospital's elected allocation basis reported in Column 1b. The allocation statistics applicable to Medicaid HMO inpatient services are reported in Column 4a and allocation statistics applicable to Medicaid HMO outpatient services are reported in Column 4b. The Medicaid HMO inpatient and outpatient statistics should be from the hospital's internal records and for the same fiscal period as the costs reported in Column 1 and total allocation statistics reported in Column 1a. If the hospital provided services to out-of-state Medicaid HMO patients, the charges related to those services should be included in Columns 3a and 3b as applicable.

Columns 4c & 4d – The Medicaid HMO inpatient and outpatient physician and/or mid-level professional costs are computed based on the CCR reported in Column 2 multiplied by the Medicaid HMO inpatient and outpatient allocation statistics reported in Columns 4a and 4b, respectively. If additional lines are added to Schedule 1, it will be necessary to copy the formula used to compute the Medicaid HMO inpatient and outpatient costs for the additional line(s).

Columns 5a & 5b - The applicable allocation statistics related to the physician and/or mid-level professional services provided to Uninsured patients are reported in Columns 5a and 5b based on the hospital's elected allocation basis reported in Column 1b. The allocation statistics applicable to Uninsured inpatient services are reported in Column 5a and allocation statistics applicable to Uninsured outpatient services are reported in Column 5b. The Uninsured inpatient and outpatient statistics should be from the hospital's internal records and for the same fiscal period as the costs reported in Column 1 and total allocation statistics reported in Column 1a.

Columns 5c & 5d – The Uninsured inpatient and outpatient physician and/or mid-level professional costs are computed based on the CCR reported in Column 2 multiplied by the Uninsured inpatient and outpatient allocation statistics reported in Columns 5a and 5b, respectively. If additional lines are added to Schedule 1, it will be necessary to copy the formula used to compute the Uninsured inpatient and outpatient costs for the additional line(s).

All revenue received by the hospital related to physician and/or mid-level professional services provided inpatients and outpatients covered by Medicaid FFS, Medicaid HMO and Uninsured patients should be reported on Line 102 of the respective Columns 3c & 3d, 4c& 4d and 5c & 5d. The revenue will be

subtracted from the respective costs to determine the net costs to be included in the hospital's UC Application.

Schedule 2

The schedule computes the pharmacy costs related to prescription drugs provided by hospitals participating in the Texas Vendor Drug program. These pharmacy costs are not related to services provided by the hospital's retail pharmacy or billed to a third party payer under revenue code 253. If the pharmacy costs were included in the hospital's Texas Medicaid DSH Application, they should not be included in the TXHUC application.

Column 1 - The total costs for the cost center that contains the drug costs related to the prescription drugs provided under the Texas Vendor Drug program are reported in Column 1, Line 1. These costs are from the hospital Medicare cost report(s) Worksheet B, Part I, last column for the applicable cost center. If the hospital cost reporting period spans September 30, the costs from the two Medicare cost reports that span the period from October 1 through September 30 two years prior to the demonstration year for which UC payments are being determined should be pro-rated and added together to determine the pharmacy costs to be reported in Column 1, Line 1.

Column 1a – The total hospital departmental charges for the cost center that contains the drug charges related to the prescription drugs provided under the Texas Vendor Drug program are reported in Column 1a, Line 1. These charges are from the hospital Medicare cost report(s) Worksheet C, Part I, Column 8 for the applicable cost center. If the hospital cost reporting period spans September 30, the charges from the two Medicare cost reports that span the period from October 1 through September 30 two years prior to the demonstration year for which UC payments are being determined should be pro-rated and added together to determine the pharmacy charges to be reported in Column 1a, Line 1.

Column 1b – The allocation basis is hospital departmental charges. If the hospital wants to utilize an alternative allocation basis, they must submit a written request to Texas HHSC that identifies the alternative allocation basis and an explanation as to why the alternative allocation basis results in a more equitable apportionment of the pharmacy costs. HHSC will provide a written response to the hospital's request within 60 days of receiving the request and their decision is final.

Column 2 – The Cost-to-Charge ratio is computed by dividing the costs reported in Column 1 by the allocation statistic reported in Column 2. The CCR is carried out to six (6) decimal places.

Column 3b – The charges related to the prescription drugs provided to Medicaid FFS patients under the Texas Vendor Drug program are reported in Column 3b, Line 1. These charges are obtained from the hospital's internal records. These charges should be for services provided during the period from October 1 through September 30 two years prior to the demonstration year for which UC payments are being determined. The hospital must maintain the supporting documentation and submit it to HHSC upon request.

Column 3d – The costs related to the prescription drugs provided to Medicaid FFS patients under the Texas Vendor Drug program are computed by multiplying the charges reported in Column 3b by the CCR computed in Column 2.

Column 4b - The charges related to the prescription drugs provided to Medicaid HMO patients under the Texas Vendor Drug program are reported in Column 4b, Line 1. These charges are obtained from the hospital's internal records. These charges should be for services provided during the period from October 1 through September 30 two years prior to the demonstration year for which UC payments are being determined. The hospital must maintain the supporting documentation and submit it to HHSC upon request.

Column 4d – The costs related to the prescription drugs provided to Medicaid HMO patients under the Texas Vendor Drug program are computed by multiplying the charges reported in Column 4b by the CCR computed in Column 2.

Column5b - The charges related to the prescription drugs provided to Uninsured patients under the Texas Vendor Drug program are reported in Column 5b, Line 1. These charges are obtained from the hospital's internal records. These charges should be for services provided during the period from October 1 through September 30 two years prior to the demonstration year for which UC payments are being determined. The hospital must maintain the supporting documentation and submit it to HHSC upon request.

Column 5d – The costs related to the prescription drugs provided to Uninsured patients under the Texas Vendor Drug program are computed by multiplying the charges reported in Column 5b by the CCR computed in Column 2.

Line 2 - All revenue received by the hospital related to prescription drug services provided to Medicaid FFS, Medicaid HMO and Uninsured patients should be reported on Line 2 of the respective Columns 3d, 4d and 5d. This includes any rebates received from the Texas Vendor Drug program. The revenue will be subtracted from the respective costs to determine the net costs to be included in the hospital's UC Application.

Schedule 3

The schedule determines the hospital's Medicaid DSH costs (Medicaid shortfall and uninsured costs) in excess of the payments received by the hospital from the Texas Medicaid DSH Program. HHSC will complete the schedule based on the hospital's DSH hospital specific limit (HSL) and the DSH Program payments received by the hospital for the applicable fiscal year (10/1/20XX – 9/30/20YY) as described in the steps below.

Line 1 - For hospitals that submitted a DSH Application to HHSC for the applicable year consisting of the applicable federal fiscal year (FFY) DSH and Cost Report Collection Form worksheets, HHSC will determine the DSH HSL to be reported on Line 1 based on the data per their DSH Application. The hospital may not submit revised data.

If the hospital submitted a complete DSH Application and did not receive a payment from the DSH Pool, HHSC will determine the HSL to be reported on Line 1based on the hospital's DSH Application submission utilizing the same methodology employed by HHSC in the determination of these costs for DSH Pool payment purposes. The hospital may not submit revised data.

If the hospital did not submit the Cost Report Collection Form worksheet as part of its DSH Application, the hospital must submit this worksheet with its TXHUC Tool. HHSC will utilize the data from the hospital's DSH worksheet along with the data per the Cost Report Collection Form to calculate the hospital's DSH HSL to be reported on Line 1. HHSC will employ the same methodology used to compute the hospital-specific DSH costs (cap) for the determination of the DSH Pool payments to compute the DSH costs (cap) for inclusion in Line 1.

If the hospital did not submit a DSH Application to HHSC, they must complete the DSH and Cost Report Collection Form worksheets in the TXHUC Tool to allow HHSC to compute their DSH HSL for inclusion in Line 1. HHSC will employ the same methodology used to determine a hospital's DSH HSL utilized in the distribution of DSH Pool payments to determine a hospital's DSH HSL to be included in Line 1.

Line 2 – HHSC will determine the Texas Medicaid DSH Program payments received by the hospital for the applicable fiscal year and report the payments on Line 2.

Line 3 – The excess hospital DSH costs are computed by subtracting the DSH payments received on Line 2 from the DSH HSL on Line 1. The excess costs will be included in the hospital's costs to determine their distribution from the UC Pool. If the hospital's DSH payments on Line 2 exceeds its DSH HSL on Line 1, the negative amount is not offset against the hospital's other UC Pool costs as computed in the TXHUC.

DSH Application

This schedule is one of the two schedules included in the Texas Medicaid DSH Application. If the hospital submitted this schedule to HHSC as part of its Medicaid DSH Application for the period from October 1, 2009 through September 30, 2010, the hospital should not complete this schedule in conjunction with the submission of the TXHUC Tool. HHSC will utilize the data per the hospital's Medicaid DSH Application to compute the amounts to be reported on Schedule 3, Line 1.

If the hospital did not submit a DSH Application to HHSC for the period from October 1 through September 30 two years prior to the demonstration year for which UC payments are being determined, the hospital should complete this schedule in accordance with the instructions contained in the Instructions-DSH Data Collection schedule. If the hospital elects to not have its excess hospital DSH costs included in its UC Pool application, the hospital is not required to complete the schedule.

Cost Report Collection Form

This schedule is the second of the two schedules included in the Texas Medicaid DSH Application. If the hospital submitted this schedule to HHSC as part of its Medicaid DSH Application for the period from October 1 through September 30 two years prior to the demonstration year for which UC payments are being determined, the hospital should not complete this schedule in conjunction with the submission of the TXHUC Tool. HHSC will utilize the data per the hospital's Medicaid DSH Application to compute the amounts to be reported on Schedule 3, Line 1.

If the hospital did not submit a DSH Application to HHSC or did not submit the Cost Report Collection Form schedule as part of its DSH Application to HHSC for the period from October 1 through September 30 two years prior to the demonstration year for which UC payments are being determined, the hospital should complete this schedule in accordance with the instructions contained in the Instructions-DSH Data Collection schedule. If the hospital elects to not have its excess hospital DSH costs included in its UC Pool application, the hospital is not required to complete the schedule.

Interim Reconciliation of Physician and Mid-Level Professional Services Payments to Hospitals

For the physician and/or mid-level professional, self-pay pharmacy and unreimbursed Medicaid DSH costs, UC payments for FFY 2012 are determined utilizing the TXHUC, which is based on data for services furnished during the 10/1/2009 – 9/30/2010. The FFY 2012 UC payments are reconciled to the costs per the as-filed Medicare cost reports for the fiscal period 10/1/2011 – 9/30/2012 once the cost report(s) have been filed with the State. If, at the end of the interim reconciliation process, it is determined that a provider received an overpayment, the overpayment will be properly credited to the federal government; if a provider was underpaid, the provider will receive an adjusted payment amount. Similar interim reconciliations will be conducted for each year of the waiver.

Final Reconciliation of Physician and Mid-Level Professional Services Payments to Hospitals

Once the Medicare cost report(s) for the expenditure year has been finalized by the Medicare Fiscal Intermediary (FI) / Medicare Administrative Contractor (MAC), a reconciliation of the finalized costs to all UC payments made for FFY 2012 will be carried out, including adjustments for overpayments and underpayments if necessary. The same method as described for the interim reconciliation will be used except that the finalized Medicare UC physician and/or mid-level professional cost amounts and updated uninsured data will be substituted as appropriate. If, at the end of the final reconciliation process, it is determined that a hospital received an overpayment, the overpayment will be properly credited to the federal government. Similar final reconciliations will be conducted for each year of the Waiver.

Texas Physician Uncompensated Care Tool (TXPUC)

The purpose of the TXPUC is to determine the physician professional costs related to services provided to Medicaid (FFS & HMO) and Uninsured patients by physician organizations in a non-hospital setting. Only professional organizations who previously participated in the Texas Medicaid Physician UPL ("Physician UPL") program are eligible to submit a TXPUC and receive a distribution from the UC Pool. Under the Physician UPL, supplemental payments were made only for physician services performed by doctors of medicine and osteopathy licensed in Texas. With effect from Demonstration Year (DY 2), all costs (direct and indirect) incurred by the physician organization related to services provided by mid-level professionals may be reported on the physician organization's UC application.

For purposes of the TXPUC Application, a mid-level professional is defined as:

- Certified Registered Nurse Anesthetist (CRNA)
- Nurse Practitioner
- Physician Assistant
- Dentist
- Certified Nurse Midwife
- Clinical Social Worker
- Clinical Psychologist
- Optometrist

The TXPUC is based on established physician and/or mid-level cost finding methodologies developed by the Medicare program over the past 40 years. The schedules that follow use the same or similar methodology and worksheet identification process used by the Medicare hospital cost report.

For all the worksheets in the TXPUC, the cells requiring input are highlighted in green. All line numbers and descriptions are linked to Worksheet A. If lines are inserted, they must be inserted on all worksheets and in the same location.

The costs to be reported in the TXPUC are limited to identifiable and auditable compensation costs that have been incurred by the physician organization for services furnished by physicians and/or mid-level

professionals in all applicable sites of service, including services provided in a hospital setting and non-hospital physician office sites for which the professional organization bills for and collects payment for the direct patient care services.

The basis for the total physicians' and/or mid-level professionals' compensation costs incurred by the professional organization will be the organization's general ledger. The costs should be representative of the services provided during the period from October 1 through September 30 two years prior to the demonstration year for which UC payments are being determined. If the organization's fiscal year straddles October 1 it will be necessary to pro-rate the costs for the two fiscal periods that comprise the period from October 1 through September 30 two years prior to the demonstration year for which UC payments are being determined.

Total costs, reported by cost centers/departments, are then allocated between clinical and non-clinical activities using a CMS-approved time-study. The physician and/or mid-level professional time study forms to be used are located on the Texas Health and Human Service Commission website. Time studies should be completed for a two (2) week period once per quarter during the fiscal year. Ideally, the time study period will not be the same two weeks in any 2 given quarters. Prior to October 1, 2012, the physician professional organization may use a CMS-approved benchmark RVU methodology in lieu of the CMS-approved time study to allocate physician compensation costs between clinical and non-clinical activities only. Effective October 1, 2012, the physician organization must utilize the CMS-approved time study to allocate physician and/or mid-level professional compensation costs between clinical and non-clinical activities. The allocation of physician and/or mid-level professional compensations costs based on the benchmark RVU methodology will not be accepted after September 30, 2012. The result of the CMS-approved time study (or the benchmark RVU methodology before October 1, 2012) is the physicians' and mid-level professionals' compensation costs pertaining only to clinical, patient care activities. The physicians' and mid-level professionals' compensation costs are reduced by National Institute of Health (NIH) grants to the extent the research activities component is not removed via physician time studies.

The physician clinical and/or mid-level professional costs are subject to further adjustments and offsets, including any necessary adjustment to bring the costs in line with Medicare cost principles. There will be an offset of revenues received for services furnished to non-patients and other applicable non-patient care revenues that were not previously offset or accounted for by the application of the CMS-approved time study.

The above physicians' and/or mid-level professionals' compensation costs must not be duplicative of any costs claimed on a hospital's TXHUC.

Additional costs that can be recognized as professional direct costs are, costs for non-capitalized medical supplies and equipment (as defined in the instructions for Worksheet A, Column 3 below) used in the furnishing of direct patient care.

Overhead costs will be recognized through the application of rate for indirect costs to be determined by the actual costs incurred by the physician organization for the applicable reporting period(s) included in the UC application. The determination of the facility-specific indirect rate is defined in the instructions for Worksheet A, Column 8 below. Other than the direct costs defined above and the application of an approved indirect rate, no other costs are allowed.

Total billed professional charges by cost center related to physician and/or mid-level professional services are identified from provider records.

The total professional charges for each cost center related to Medicaid fee-for-service (FFS), Medicaid managed care (HMO), and uninsured physician and/or mid-level professional services, billed directly by the professional organization, are identified using auditable financial records. Professional charges related to services provided to out-of-State Medicaid FFS and HMO patients should be included in the Medicaid charges reported on the TXPUC. The professional organization must map the claims to the respective cost centers using information from their billing systems. Each charge must be mapped to only one cost center to prevent duplicate mapping and claiming. These charges must be associated with services furnished during the period covered by the TXPUC (the period from October 1 through September 30 two years prior to the demonstration year for which UC payments are being determined). The professional organization must prepare a worksheet that identifies professional charges related to physician and/or mid-level professional services provided to patients covered by Medicaid FFS, Medicaid HMO, uninsured and all other payers for each cost center to be used to report the total charges on Worksheet B and the Program charges on Worksheet D. The worksheet total charges must be reconciled to the total charges per the professional organization's general ledger and/or financial statements for the applicable fiscal period(s).

Certification

The certification page must be signed and dated by an officer or administrator of the provider. An officer is defined as a member of the entity's senior management such as the chief executive officer, chief financial officer, chief operating officer, etc. The certification must contain an original signature and not a copy or electronic signature.

Upon the termination of the 1115 Waiver, entities will be required to submit actual cost data in the prescribed format of the TXPUC for a minimum of two years for purposes of reconciling the UC Pool payments for the last two years of the Waiver with the provider's actual costs incurred for those fiscal periods

Summary Schedule

Column 1 - Summarizes the Medicaid and Uninsured costs determined on the applicable columns from Worksheet D. These amounts will flow automatically from the respective columns and no input is required.

Column 2 – The distribution of the Uncompensated Care Pool ("UC Pool") for a specific demonstration year will be based on the costs for the period from October 1 through September 30 two years prior to the demonstration year as computed on Worksheet D. If the entity knows these costs are not representative of their actual costs for the demonstration year, due to changes in their contractual arrangements or other operational or economic issues, the entity can make an adjustment to these costs. The entity is required to maintain supporting documentation to support their adjustment amount and make this information available upon request from HHSC and/or CMS.

Column 3 – Represents the net Medicaid and Uninsured costs after any adjustments and is determined by summing the amounts in Columns 1 & 2. The net cost amount will be utilized to determine the entity's distribution from the UC Pool.

Worksheet A

This worksheet is a summary of the allowable direct patient care costs for physicians and mid-level professionals. The worksheet is segregated into 3 sections. Lines 1 – 29 contain the costs for physicians and mid-level professionals for patient care services provided in a hospital-based setting. Lines 31 – 55 contain the costs for physicians and mid-level professionals for patient care services provided in a non-hospital-based setting. Lines 56 – 79 contain costs for physicians and mid-level professionals for patient care services provided in settings other than those identified in Sections 1 and 2.

Cost center descriptions are input on this worksheet and will flow to the other worksheets. If lines are added to this worksheet to accommodate the professional organization's unique cost centers, similar lines will need to be added to the other worksheets.

The professional organization's name, provider number, reporting period and indirect cost rate should be input on this worksheet and will flow to the other worksheets.

Column 1 – Physicians' and mid-level professionals' costs determined on Worksheet A-1 will flow to this column.

Column 2 – This column will not be utilized at this time.

Column 3 – Non-capital equipment and supplies costs related to direct patient care are input in this column. Non-capital equipment would be items such as the purchase of reusable surgical trays, scalpels or other medical equipment whose costs are expensed upon acquisition since they are below the organization's threshold for capitalization. Supplies would be items such as disposable supplies utilized during the treatment of patients (sutures, gauze pads, tape, bandages, needles and syringes, splints, etc.). The source for these costs is the professional organization's accounting records. The source for these costs must be maintained by the professional organization and submitted to HHSC or CMS upon request.

Column 4 – This column is the sum of Columns 1, and 3. If line(s) have been added to the worksheet, it will be necessary to copy the formula in this column from an existing line to the line(s) that were added.

Column 5 – Any reclassification of costs reported on Worksheet A-6 will flow to this column.

Column 6 – This column is the sum of Columns 4 and 5. If line(s) have been added to the worksheet, it will be necessary to copy the formula in this column from an existing line to the line(s) that were added.

Column 7 - Any adjustments of costs reported on Worksheet A-8 will flow to this column. For example, revenue received for National Institute of Health (NIH) grants, to the extent the research activities component is not removed via physician and/or mid-level professional time studies should be reported on this Worksheet.

Column 8 – The indirect costs in this column are computed based on the costs reported in Column 6 multiplied by the indirect cost rate for the professional organization. The indirect cost rate will be determined based on the professional organization's actual indirect costs to its total direct costs (allowable and nonallowable) for the applicable reporting period(s) covered by the UC application. If the professional organization's fiscal period does not coincide with the reporting period covered by the UC application, the indirect cost ratio for the two periods should be weighted based on the number of months each period is within the UC application reporting period to determine the organization's actual indirect cost ratio. The professional organization's costs per its general ledger for the applicable fiscal period(s) should be used to identify the allowable direct and indirect costs to be used to compute the indirect cost rate. The indirect cost rate should be rounded to two (2) decimal places (e.g. 22.58%). The professional organization must submit its calculation of its indirect cost rate with its UC application.

Allowable indirect costs are defined as costs incurred by the professional organization in support of the physicians' and mid-level professionals' direct patient care services, regardless of the location where these services are performed. Medicare cost finding principles should be used to determine allowable indirect costs. Allowable indirect costs would include, but are not limited to, nurse staff and other support personnel salaries and fringe benefits involved in direct patient care, billing and administrative personnel salaries and fringe benefits related to direct patient care, space costs (building and equipment depreciation or lease, interest, utilities, maintenance, etc.) related to the space utilized to provide care to patients. Nonallowable indirect costs would include but are not limited to; advertising for the purpose of increasing patient utilization, bad debts related to accounts receivable, gain or loss on the sale of depreciable assets, fines or penalties imposed by local, state or federal government or their agencies. Any fringe benefits cost related to the physicians' and mid-level professionals' compensation costs should be included in Columns 1 and/or 2 of Worksheet A should not be included in the allowable indirect costs. The non-capital equipment and supply costs reported in Column 3 of Worksheet A above should also be excluded from allowable indirect costs.

Total costs would be determined based on the professional organization's total expenses per its general ledger. The following is an illustrative example of the calculation of an indirect cost rate for a professional organization.

UC application reporting period	**10/1/2009 - 9/30/2010**	
Fiscal year end of professional organization	12/21/2009	12/31/2010
Total expenses per the general ledger	25,000,000	28,600,800
Bad Debts	(800,000)	(923,000)
Loss on sale of depreciable assets	(200,000)	(123,000)
N/A Advertising Expenses	(111,000)	(133,000)
Physician and mid-level professional compensation (from Col. 1)	(11,500,700)	(13,600,200)
Non capital equipment and supplies (from Col. 3)	(765,000)	(842,000)
Allowable Direct Expenses	(12,265,700)	(14,442,200)

Allowable indirect costs	11,623,300	12,979,600
Total direct costs	13,376,700	15,621,200
Indirect cost ratio	86.89%	83.09%
Weighted indirect cost ratio	21.72%	62.32%
Allowable indirect cost ratio		84.04%

Column 9 – This column is the total physicians' and mid-level professionals' costs that flow to Worksheet B, Column 1. It is the sum of Columns 6, 7 and 8. If line(s) have been added to the worksheet, it will be necessary to copy the formula in this column from an existing line to the line(s) that were added.

Worksheet A-1
This worksheet determines the physicians' and/or mid-level professionals' compensation costs for direct patient care services. These costs are determined separately for services provided in a hospital-based and non-hospital based setting. If there are services provided in a unique setting, these costs are determined in Section 3. If a physician provides services in more than one setting, it will be necessary to report his/her data for each applicable setting separately. Data on this worksheet should be reported based on the physicians' and/or mid-level professionals' specialty/cost center identified on the worksheet.

Physicians' and/or mid-level professionals' compensation costs are comprised of the direct payments made by the professional organization to the physician and/or mid-level professional for all services provided by the physician and/or mid-level professional on behalf of the professional organization. These costs would be salaries and related fringe benefits, payments under a contractual arrangement between the physician and/or mid-level professional and the professional organizations, funding of a retirement and/or deferred compensation plan by the professional organization on behalf of the physician, and costs related to a health and/or long-term disability program for the physician and his/her dependents.

If the professional organization has a physician and/or mid-level professional time study to allocate the physicians' and/or mid-level professionals' compensation costs to direct patient care services and the physicians' and/or mid-level professionals' other activities, it is not necessary to complete this worksheet. The professional organization can complete a supporting schedule in which the time study can be applied to the physicians' and/or mid-level professionals' compensation costs and the result should be input directly in Column 1 of Worksheet A. In the absence of a physician and/or mid-level professional time study to allocate the physicians' and/or mid-level professionals' compensation costs between direct patient care services and the physicians' and/or mid-level professionals' other activities prior to 10-1-2012, the costs for direct patient care services will be determined based on each physician's work Relative Value Units (RVUs) for direct patient care. Effective 10-1-2012, professional organizations are expected to obtain a time study from each physician and/or mid-level professional to be used in the allocation of the physicians' and/or mid-level professionals' compensation costs to direct patient care services and other activities. The physician and/or mid-level professional time study forms to be used are located on the Texas Health and Human Services website. Time studies should be completed for a two (2) week period once per quarter during the fiscal year. Ideally, the time study period will not be the same two weeks in any two given quarters.

If a professional organization incurs costs for services provided by another entity under a contractual arrangement, those costs can be included. The professional organization would be required to offset the revenue received on its UC Application to eliminate any duplicate payment for the costs related to these services.

Column 1 – The physicians' and/or mid-level professionals' work RVUs are reported in this column for periods prior to 10-1-2012. The source for the work RVUs are the professional organization's internal records. The source for the work RVUs should be maintained by the professional organization and made available upon request by HHSC and/or CMS. An individual physicians' and/or mid-level professionals' work RVUs cannot exceed the benchmark RVU for one FTE. For periods after 10-1-2012, the physician's and/or mid-level professionals' time related to direct patient care activities based on their time study is reported in this column.

Column 2 – The benchmark RVU for an FTE for each physician and/or mid-level professional specialty is reported in this column for periods prior to 10-1-2012. The benchmark RVUs for each physician specialty FTE are contained in the Benchmark RVU worksheet of the TXPUC. If the professional organization has a physician specialty that is not listed on the Benchmark RVU worksheet, the benchmark RVU for the physician specialty most closely related to the actual physician specialty should be utilized. The benchmark RVU must be multiplied by the number of physicians and mid-level professionals included in each cost center to determine the benchmark RVU to be reported in this column. For periods after 10-1-2012, the physician's total time related to the physician's compensation reported in Column 4 based on their time study is reported in this column.

Column 3 – The RVU percentage is computed based on the actual physicians' and mid-level professionals' RVUs reported in Column 1divided by the benchmark RVUs reported in Column 2 for each line. The RVU percentage should not exceed 1.00000. If line(s) have been added to the worksheet, it will be necessary to copy the formula in this column from an existing line to the line(s) that were added.

Column 4 – The physicians' and mid-level professionals' compensation costs for each physician and/or mid-level professional/specialty/cost center are reported in this column. The source for the compensation costs are the professional organization's internal records. The source for the physicians' and mid-level professionals' compensation costs should be maintained by the professional organization and made available upon request by HHSC and/or CMS.

Column 5 – The physicians' and mid-level professionals' compensation costs for direct patient care services are computed based on the RVU percentage in Column 3 multiplied by the total physicians' and mid-level professionals' compensation costs reported in Column 4. If line(s) have been added to the worksheet, it will be necessary to copy the formula in this column from an existing line to the line(s) that were added. The costs in this column flow to Worksheet A, Column 1.

Worksheet A-6

This reclassification worksheet is similar to the Worksheet A-6 in the Hospital 2552 Medicare cost report. It allows for the reclassification of costs between cost centers reported on Worksheet A. Any reclassifications reported on this worksheet will need to be input on Worksheet A, Column 5 in the applicable line.

Worksheet A-8

This adjustments worksheet is similar to the Worksheet A-8 in the Hospital 2552 Medicare cost report. It allows for any required adjustment(s) to the costs reported on Worksheet A (e.g. NIH grant revenue if research costs are not identified via the time studies). All payments received for services provided to another entity's patients should be offset against the applicable costs. All payments received from another entity to subsidize the care provided to a patient who was referred by the entity should be offset against the applicable costs. Any adjustments reported on this worksheet will need to be input on Worksheet A, Column 7 in the applicable line.

Worksheet B

The worksheet calculates the cost-to-charge ratio (CCR) to be utilized in apportioning the physicians' and/or mid-level professionals' compensation costs for services provided to Medicaid and Uninsured patients that is the basis for the determination of the professional organization's distribution from the UC Physician Pool.

Column 1 – The net physicians' and mid-level professionals' costs from Worksheet A, Column 8 will flow to this column.

Column 2 – The physicians' and/or mid-level professionals' total billed charges are reported in this column. As an alternative, the professional organization can use the number of visits as the allocation basis to apportion the costs. If the professional organization does elect to utilize patient visits to apportion the costs, the allocation basis reported at the top of this column should be changed from Total Billed Charges to Patient Visits. For either allocation basis, the source for this data will be the professional organization's internal records. If the professional organization's fiscal period straddles October 1, it will be necessary to pro-rate the data from the two fiscal periods that encompass the period from October 1 through September 30 two years prior to the demonstration year for which UC payments are being determined.

Column 3 – The CCR is computed by dividing the costs reported in Column 1 of this worksheet by the total allocation basis reported in Column 2 of this worksheet.

Worksheet D

This worksheet computes the physicians' and/or mid-level professionals' costs for services provided to Medicaid FFS, Medicaid HMO and Uninsured patients. It utilizes the CCR determined on Worksheet B, Column 3 and the charges for physician and/or mid-level professional services. The source for the Medicaid FFS, Medicaid HMO and Uninsured data are the professional organization's internal records. If the professional organization's fiscal period straddles October 1, it will be necessary to pro-rate the data from the two fiscal periods that encompass the period from October 1 through September 30 two years prior to the demonstration year for which UC payments are being determined. The allocation basis reported on Worksheet B Column 2 must be the same as the apportionment basis reported on Worksheet D, Columns 2 – 7. If the professional organization elects to utilize patient visits to apportion the costs

rather than billed charges, the apportionment basis at the top of Columns 2 – 7 should be changed from Billed Charges to Patient Visits.

Column 1 – The CCR from Worksheet B, Column 3 flows to this column.

Columns 2 through 7 – The apportionment statistics for inpatient and outpatient services provided to Medicaid FFS, Medicaid HMO and Uninsured patients are reported in the respective columns.

Columns 8 – 13 – The physicians' and mid-level professionals' costs for inpatient and outpatient services provided to Medicaid FFS, Medicaid HMO and Uninsured patients are computed by multiplying the CCR reported in Column 1 multiplied by the apportionment statistics reported in Columns 2 – 7 for the respective columns.

The total costs for each column are determined at the bottom of the worksheet. All revenues received from any source related to the physician and/or mid-level professional services provided to Medicaid FFS, Medicaid HMO and Uninsured should be reported on the Less Payments line at the bottom of the worksheet in the respective column. This would include any payments received from third-party payers, patient copays, etc.

The Net Unreimbursed Cost for Columns 8 through 13 flows to the Cost Summary worksheet of the TXPUC tool. This cost will be utilized to determine the professional organization's distribution from the UC Physician Pool.

Interim Reconciliation of Physician Payments to Professional Organizations

The physician UC payments for FY 2012 are determined utilizing the TXPUC that utilizes data for the fiscal period 10/1/2009 – 9/30/2010. These FY 2012 UC payments are reconciled to the data per the professional organization's TXPUC for the fiscal period 10/1/2011 – 9/30/2012 once the TXPUC has been filed with the State. If, at the end of the interim reconciliation process, it is determined that a provider received an overpayment, the overpayment will be properly credited to the federal government; if a provider was underpaid, the provider will receive an adjusted payment amount. Similar interim reconciliations will be conducted for each year of the waiver.

Final Reconciliation of Physician Payments to Professional Organizations

Once the TXPUC for the expenditure year has been finalized by the State, a reconciliation of the finalized costs per the TXPUC to all UC payments made for the same period will be carried out, including adjustments for overpayments and underpayments if necessary. The same method as described for the interim reconciliation will be used except that the finalized TXPUC physician and/or mid-level professional cost amounts and updated uninsured data will be substituted as appropriate. If, at the end of the final reconciliation process, it is determined that a hospital received an overpayment, the overpayment will be properly credited to the federal government. Similar final reconciliations will be conducted for each year of the Waiver.