DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S3-14-28
Baltimore, Maryland 21244-1850

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

**Center for Medicaid and CHIP Services**

Mr. Billy Millwee
Associate Commissioner for Medicaid & CHIP
Health and Human Services Commission
Post Office Box 13247
Austin, Texas 78711

OCT 13 2011

RE: TN 10-62

Dear Mr. Millwee:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 10-62. This amendment revises language in the disproportionate share hospital (DSH) reimbursement methodology.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a), and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. As part of the review process the State was asked to provide information regarding funding of the State share of expenditures under Attachment 4.19-A. Based upon your assurances, Medicaid State plan amendment 10-62 is approved effective October 1, 2010. We are enclosing the HCFA-179 and the amended plan pages.

If you have any questions, please call Sandra Dasheiff, CPA at (214) 767-6490.

Sincerely,

[redacted]

Cindy Mann
Director
Center for Medicaid and CHIP Services

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0193

**TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL**
**FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES**

1. TRANSMITTAL NUMBER: **10-062**
2. STATE: **TEXAS**
3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE AND MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: **October 1, 2010**

5. TYPE OF PLAN MATERIAL *(Circle One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
**Social Security Act § 1923**

7. FEDERAL BUDGET IMPACT: SEE ATTACHMENT
a. FFY **2011** **$0**
b. FFY **2012** **$0**
c. FFY **2013** **$0**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
**SEE ATTACHMENT TO BLOCKS 8 & 9**

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
**SEE ATTACHMENT TO BLOCKS 8 & 9**

10. SUBJECT OF AMENDMENT:
**The amendment revises language in the Disproportionate Share Hospital (DSH) reimbursement methodology.**

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: Sent to Governor's Office this date. Comments, if any, will be forwarded upon receipt.

12. SIGNATURE OF STATE AGENCY OFFICIAL:
[redacted]

13. TYPED NAME:
**Billy R. Millwee**

14. TITLE:
**State Medicaid Director**

15. DATE SUBMITTED:
**December 28, 2010**

16. RETURN TO:
**Billy R. Millwee**
**State Medicaid Director**
**Post Office Box 85200**
**Austin, Texas 78711-5200**

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED: 29 December, 2010

18. DATE APPROVED: OCT 13 2011

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
OCT - 1 2010

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME: Penny Thompson

22. TITLE: Deputy Director, CMCS

23. REMARKS:

FORM CMS – 179 (07-92)

**Attachment to Blocks 8 & 9 to CMS Form 179**

**Transmittal No. 10-062, Amendment No. 955**

| Number of the Plan Section or Attachment | Number of the Superseded Plan Section or Attachment |
|---|---|
| Appendix 1 to Attachment 4.19-A | Appendix 1 to Attachment 4.19-A |
| Page 1 | Page 1 (TN 09-033) |
| Page 2 | Page 2 (TN 09-033) |
| Page 3 | Page 3 (TN 09-033) |
| Page 4 | Page 4 (TN 09-033) |
| Page 5 | Page 5 (TN 09-033) |
| Page 6 | Page 6 (TN 09-033) |
| Page 7 | Page 7 (TN 09-033) |
| Page 8 | Page 8 (TN 09-033) |
| Page 9 | Page 9 (TN 09-033) |
| Page 10 | Page 10 (TN 09-033) |
| Page 11 | Page 11 (TN 09-033) |
| Page 12 | Page 12 (TN 09-033) |
| Page 13 | Page 13 (TN 09-033) |
| Page 14 | Page 14 (TN 09-033) |
| Page 15 | Page 15 (TN 09-033) |
| Page 16 | Page 16 (TN 09-033) |
| Page 17 | Page 17 (TN 09-033) |
| Page 18 | Page 18 (TN 09-033) |

**Disproportionate Share Hospital (DSH) Reimbursement Methodology**

(a) Introduction. Hospitals participating in the Texas Medicaid program that meet the conditions of participation and that serve a disproportionate share of low-income patients are eligible for additional reimbursement from the disproportionate share hospital (DSH) fund. HHSC will establish each hospital's eligibility for, and amount of, reimbursement. This section applies to all hospitals that participate in the DSH program.

(b) Definitions. For the purposes of this section, the following words and terms have the following meanings unless the context clearly indicates otherwise.

(1) Adjudicated claim – A hospital claim for payment for a covered Medicaid service that is paid or adjusted by HHSC or another payer.

(2) Available DSH funds – The annual federal DSH allotment of funds that may be reimbursed to all DSH-eligible providers.

(3) Bad Debt – A debt arising when there is non-payment on behalf of an individual who has third-party coverage.

(4) Charity care – The unreimbursed cost to a hospital of providing, funding, or otherwise financially supporting health care services on an inpatient or outpatient basis to indigent individuals, either directly or through other nonprofit or public outpatient clinics, hospitals, or health care organizations. A hospital must set the income level for eligibility for charity care consistent with the criteria established in §311.031, Texas Health and Safety Code.

(5) 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.

(6) Children's hospital – A hospital within Texas that is recognized by Medicare as a children's hospital and is exempted by Medicare from the Medicare prospective payment system.

**Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)**

**Definitions (continued)**

(7) Disproportionate share hospital – A hospital identified by HHSC that meets the DSH program conditions of participation and that serves a disproportionate share of Medicaid and/or indigent patients.

(8) DSH data year – A twelve-month period from which HHSC will compile data to determine DSH program qualification and payment.

(9) DSH program year – The twelve-month period beginning October 1 and ending September 30. This corresponds with the Medicaid state plan rate year.

(10) Dually eligible patient – A patient who is simultaneously eligible for Medicare and Medicaid.

(11) Hospital-specific limit – The maximum amount a hospital may receive in a DSH program year, based on costs arising from individuals receiving hospital services who are Medicaid eligible or uninsured, not costs arising from individuals who have third-party coverage.

(A) An interim hospital-specific limit will be trended forward to the DSH program year using an inflation update factor to account for inflation since the DSH data year.

(B) A final hospital-specific limit will be calculated using actual DSH program year cost and payment data.

(12) Independent certified audit – An audit that is conducted by an auditor that operates independently from the Medicaid agency and the audited hospitals and that is eligible to perform the DSH audit required by CMS.

(13) Indigent individual – An individual classified by a hospital as eligible for charity care.

**Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)**

**Definitions (continued)**

(14) Inflation update factor – Cost-of-living index based on the annual Centers for Medicare & Medicare Services prospective payment system hospital market basket index.

(15) Inpatient day – Each day that an individual is an inpatient in the hospital, whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere. The term includes observation days, rehabilitation days, psychiatric days, and newborn days. The term does not include swing bed days or skilled nursing facility days.

(16) Inpatient revenue – Amount of gross inpatient revenue (charges) derived from the most recent completed Medicaid cost report or reports related to the applicable DSH data year. Gross inpatient revenue excludes revenue related to the professional services of hospital-based physicians, swing bed facilities, skilled nursing facilities, intermediate care facilities, other non-hospital revenue, and revenue not identified by the hospital.

(17) Institution for Mental Disease (IMD) – A hospital that is primarily engaged in providing psychiatric diagnosis, treatment, or care of individuals with mental illness.

(18) Low-income days – Number of inpatient days attributed to indigent patients.

(19) Low-income utilization rate – A DSH qualification criterion calculated as described in subsection (c)(2).

(20) Mean Medicaid inpatient utilization rate – The average of all active Medicaid hospitals' Medicaid inpatient utilization rates.

(21) Medicaid contractor – Fiscal agents and managed care organizations with which HHSC contracts to process data related to the Medicaid program.

(22) Medicaid cost report – *Hospital and Hospital Health Care Complex Cost Report* (Form CMS 2552), also known as the Medicare cost report.

**Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)**

**Definitions (continued)**

(23) Medicaid hospital – A hospital meeting the qualifications to participate in the Texas medical assistance program.

(24) Medicaid inpatient utilization rate – A DSH qualification criterion calculated as described in subsection (c)(1).

(25) Medicaid shortfall – The unreimbursed cost of Medicaid inpatient and outpatient hospital services furnished to Medicaid patients.

(26) Medicaid state plan rate year – The twelve-month period corresponding to the DSH program year.

(27) Metropolitan statistical area (MSA) –As defined by the United States Office of Management and Budget. MSAs with populations greater than or equal to 121,000, according to the most recent decennial census, are considered "the largest MSAs."

(28) Obstetrical services – The medical care of a woman during pregnancy, delivery, and the post-partum period provided at the hospital listed on the DSH application.

(29) Outpatient charges – Amount of gross outpatient charges (revenue) related to the applicable DSH data year and used in the calculation of the Medicaid shortfall.

(30) Primary metropolitan statistical area (PMSA) – As defined by the United States Office of Management and Budget.

(31) Ratio of cost-to-charges (inpatient only) –A cost center ratio that covers all applicable hospital costs and charges relating to inpatient care. This ratio does not distinguish between payer types such as Medicare, Medicaid, or private pay.

**Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)**

**Definitions (continued)**

(32) Ratio of cost-to-charges (inpatient and outpatient) – A Medicaid cost report derived cost center ratio that covers all applicable hospital costs and charges relating to patient care, inpatient and outpatient. This ratio does not distinguish between payer types such as Medicare, Medicaid, or private pay.

(33) Rural area – Area outside an MSA or a PMSA.

(34) State chest hospital – A public health facility operated by the Department of State Health Services and designated for the care and treatment of patients with tuberculosis.

(35) State-owned teaching hospital – A hospital owned and operated by a state university or other state agency.

(36) Third-party coverage – Creditable insurance coverage consistent with the definitions in 45 Code of Federal Regulations (CFR) Parts 144 and 146, or coverage based on a legally liable third-party payer.

(37) Total Medicaid inpatient days – Total number of inpatient days based on adjudicated claims data for covered services for state fiscal year 2008 for DSH program year 2010. Beginning with DSH program year 2011, the relevant DSH data year will be used for Medicaid-eligible patients.

(A) The term includes:

(i) Medicaid-eligible days of care adjudicated by managed care organizations;

(ii) days that were denied payment for spell-of-illness limitations;

(iii) days attributable to individuals eligible for Medicaid in other states, including dually eligible patients;

(iv) only days with adjudicated dates during the period; and

(v) days for dually eligible patients for purposes of the calculation in (c)(1).

(B) The term excludes:

**Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)**

**Definitions (continued)**

(B) The term excludes:

(i) days attributable to Medicaid patients between the ages of 21 and 65 in an IMD; and

(ii) days denied for late filing and other reasons; and

(iii) days for dually eligible patients for purposes of the calculation in (c)(3).

(38) Total Medicaid inpatient hospital payments – Total amount of Medicaid funds that a hospital received for adjudicated claims for inpatient services during the DSH data year. The term includes payments that the hospital received:

(A) for inpatient services from managed care organizations; and

(B) for patients eligible for Medicaid in other states.

(39) Total state and local revenue – Total amount of state and local payments that a hospital received for inpatient care during the DSH data year. The term includes payments under state and local programs that are funded entirely with state general revenue funds and state or local tax funds and contractual discounts and allowances.

(40) Uninsured cost – The cost to a hospital of providing inpatient and outpatient hospital services as defined by CMS.

(41) Uninsured patient – An individual who has no health insurance or other source of third-party coverage.

**Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)**

**Definitions (continued)**

(42) Upper Payment Limit (UPL) program – Supplemental Medicaid payments made to certain eligible hospitals for inpatient and outpatient services based on state and federal guidelines.

(43) Weighted low-income days – Low-income days that are adjusted based on the population of the MSA or PMSA in which a hospital is located.

(44) Weighted Medicaid days – Medicaid days that are adjusted based on the population of the MSA or PMSA in which a hospital is located.

(c) Qualification. For each DSH program year, in addition to meeting the eligibility requirements, applicants must meet at least one of the following qualification criteria, which are determined using information from a hospital's application, the annual hospital survey, or from HHSC's Medicaid contractors, as specified by HHSC:

(1) Medicaid inpatient utilization rate. A hospital's inpatient utilization rate is calculated by dividing the hospital's Medicaid inpatient days by its total inpatient census days for the DSH data year.

(A) Rural hospital: A rural hospital must have a Medicaid inpatient utilization rate greater than the mean Medicaid inpatient utilization rate for all Medicaid hospitals.

(B) Urban hospital: An urban hospital must have a Medicaid inpatient utilization rate that is at least one standard deviation above the mean Medicaid inpatient utilization rate for all Medicaid hospitals.

(2) Low-income utilization rate. A hospital must have a low-income utilization rate greater than 25 percent.

(A) The low-income utilization rate is the sum (expressed as a percentage) of the fractions calculated in (i) and (ii) of this subparagraph:

**Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)**

**Qualification (continued)**

(i) The sum of the total Medicaid inpatient hospital payments and the total state and local revenue paid to the hospital for inpatient care in the DSH data year, divided by a hospital's gross inpatient revenue multiplied by the hospital's ratio of cost-to-charges (inpatient only) for the same period: (Total Medicaid Inpatient Hospital Payments + Total State and Local Revenue)/(Gross Inpatient Revenue x Ratio of Costs to Charges).

(ii) Inpatient charity charges in the DSH data year minus the amount of payments for inpatient hospital services received directly from state and local governments, excluding all Medicaid payments, in the DSH data year, divided by the gross inpatient revenue in the same period: (Total Inpatient Charity Charges - Total State and Local Payments)/Gross Inpatient Revenue.

(iii) If a hospital fails to allocate state and local tax revenue between the inpatient and outpatient revenue, HHSC will make the proportional allocation using data contained in the latest available Medicaid cost report(s) or Medicaid cost report for the DSH data year.

(B) HHSC will determine the ratio of cost-to-charges (inpatient only) by using information from the appropriate worksheets of each hospital's Medicaid cost report or reports that correspond to the DSH data year. In the absence of a Medicaid cost report for that period, HHSC will use the latest available submitted Medicaid cost report or reports.

(3) Total Medicaid inpatient days.

(A) A hospital must have Medicaid inpatient days at least one standard deviation above the mean Medicaid inpatient days for all hospitals participating in the Medicaid program, except:

**Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)**

**Qualification (continued)**

(B) A hospital in an urban county with a population of 250,000 persons or fewer, according to the most recent decennial census, must have Medicaid inpatient days at least 70 percent of the sum of the mean Medicaid inpatient days for hospitals in this subset plus one standard deviation above that mean.

(C) Days for dually eligible patients are not included in the calculation of total Medicaid inpatient days under this paragraph.

(4) Children's hospitals. Children's hospitals that do not otherwise qualify as disproportionate share hospitals will be deemed disproportionate share hospitals.

(5) Merged hospitals. HHSC will aggregate the data used to determine qualification under this subsection from the merged hospitals to determine whether the single Medicaid provider that results from the merger qualifies as a Medicaid disproportionate share hospital.

(d) Conditions of participation. Each hospital will certify during the application process that, as of the date of the certification, it meets and will continue to meet during the DSH program year the following conditions of participation:

(1) Two-physician requirement. A hospital must have at least two licensed physicians (doctor of medicine or osteopathy) who have hospital staff privileges and who have agreed to provide non-emergency obstetrical services to individuals who are entitled to medical assistance for such services. The two physician requirement does not apply to a children's hospital or to a hospital that was operating but did not offer non-emergency obstetrical services as of December 22, 1987.

(2) Medicaid inpatient utilization rate. Each hospital must have a Medicaid inpatient utilization rate of at least one percent. A hospital's inpatient utilization rate is calculated by dividing the hospital's Medicaid inpatient days by its total inpatient census days.

**Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)**

**Conditions of participation (continued)**

(3) Compliance with audit requirements. A hospital must agree to comply with the audit requirements described in (h).

(e) Calculating a hospital-specific limit. HHSC annually will determine the interim hospital-specific limit for each hospital applying for DSH funds in compliance with (e)(1) - (3). HHSC will also determine the final hospital-specific limit in (e)(4).

(1) HHSC will calculate a hospital's interim hospital-specific limit by adding the hospital's net uninsured costs and its Medicaid shortfall, both adjusted for inflation.

(2) HHSC will determine the individual components of the hospital-specific limit as follows:

(A) Uninsured costs.

(i) Each hospital will report in its DSH application its inpatient and outpatient charges incurred for services to uninsured patients admitted during the DSH data year.

(ii) Each hospital will report in its DSH application all payments received for services to uninsured patients admitted during the DSH data year.

(I) For purposes of this rule, a payment received is any payment from an uninsured patient or from a third party (other than an insurer) on the patient's behalf, including payments received for emergency health services furnished to undocumented aliens under section 1011 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, except;

**Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)**

**Conditions of participation (continued)**

(II) State and local payments to hospitals for indigent care are not included as payments made by or on behalf of uninsured patients.

(iii) HHSC will convert uninsured charges to uninsured costs using the ratio of cost-to-charges (inpatient and outpatient) as calculated in (e)(3).

(iv) HHSC will subtract all payments received under (ii) from the uninsured costs under clause (iii), resulting in net uninsured costs.

(B) Medicaid shortfall.

(i) HHSC will request from its Medicaid contractors the inpatient and outpatient Medicaid charge and payment data for claims adjudicated during the DSH data year for all active Medicaid participating hospitals. There are circumstances, including the following, in which HHSC will request modifications to the adjudicated data.

(I) HHSC will include as appropriate:

(-a-) Charges and payments associated with the care of dually eligible patients, including Medicare charges and payments; and

(-b-) Charges for claims or portions of claims that were not paid because they exceeded the spell-of-illness limitation.

(II) HHSC will exclude:

**Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)**

**Calculating a hospital-specific limit (continued)**

(-a-) Charges associated with services not covered by Medicaid as well as charges associated with claims from the Children's Health Insurance Program or the Women's Health Program; and

(-b-) Charges associated with claims submitted after the 95-day filing deadline.

(ii) HHSC will review the information for accuracy and make additional adjustments as necessary.

(iii) HHSC will convert the Medicaid charges to Medicaid costs using the ratio of cost-to-charges (inpatient and outpatient) as calculated under (e)(3).

(iv) HHSC will subtract each hospital's Medicaid payments, including cost report settlements, supplemental payments (including upper payment limit payments) and graduate medical education payments, from its Medicaid costs.

(v) If a hospital's payments are less than its costs, the hospital has a positive Medicaid shortfall. If a hospital's payments are greater than its costs, the hospital has a negative Medicaid shortfall. A negative Medicaid shortfall will still be used in the calculation in (e)(1).

(vi) If, subsequent to the DSH data year, the inpatient hospital reimbursement rebasing significantly impacts the accuracy of the Medicaid shortfall, HHSC will apply an adjustment factor to Medicaid inpatient payment data.

(C) Inflation adjustment.

**Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)**

**Calculating a hospital-specific limit (continued)**

(i) HHSC will trend each hospital's hospital-specific limit using the inflation update factor from (b)(14).

(ii) HHSC will use the inflation update factors for the period beginning at the midpoint of each DSH data year to the midpoint of the DSH program year.

(iii) HHSC will multiply each hospital's sum of the net uninsured costs and Medicaid shortfall by the inflation update factor to obtain its interim hospital-specific limit.

(3) Ratio of cost-to-charges. HHSC will calculate the ratio of cost-to-charges used in setting hospital-specific limits in conformity with the following conditions and procedures:

(A) HHSC will convert to cost the portion of the total Medicaid charges related to adjudicated claims that are allocated to the various cost centers of the hospital. The ratio is derived by allocating allowable charges to each cost center.

(B) HHSC will calculate the ratio of cost-to-charges for the respective cost centers using information from the appropriate worksheets of the hospital's Medicaid cost report or reports corresponding to the DSH data year. In the absence of a Medicaid cost report for that period, HHSC will use the latest available submitted Medicaid cost report or reports.

(C) HHSC will exclude those costs and charges for nonhospital services such as ambulance, rural health clinics, primary home care, home health agencies, hospice, and skilled nursing facilities.

(4) Final hospital-specific limit.

**Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)**

**Calculating a hospital-specific limit (continued)**

(A) HHSC will calculate the individual components of a hospital's final hospital-specific limit using the calculation set out in (e)(2) and (3), except that HHSC will use the hospital's actual costs incurred and payments received during the DSH program year.

(B) The final hospital-specific limit will be used in the audit conducted under subsection (h) of this section.

(f) Distribution of available DSH funds. Before the start of each DSH program year, CMS publishes the federal DSH allotment for each state. Based on CMS's DSH allotment for Texas, HHSC validates and distributes the entire allotment to eligible qualifying DSH hospitals during the DSH program year. HHSC will distribute the available DSH funds among such hospitals using the following priorities:

(1) State-owned teaching hospitals and state chest hospitals. HHSC will reimburse state-owned teaching hospitals and state chest hospitals an amount equal to their interim hospital-specific limits.

(2) IMDs.

(A) Limits. Aggregate payments made to IMD facilities statewide are subject to federally mandated reimbursement limits.

(B) State IMDs. HHSC will reimburse a state-owned or state-operated IMD a prorated share based on the amount of each state IMD's interim hospital-specific limit.

(C) Non-state IMDs. A non-state IMD is reimbursed as other non-state hospitals.

(D) Amount. A non-state IMD that satisfies the DSH requirements and provides inpatient psychiatric services receives up to 100 percent of its interim hospital-specific limit within available DSH funds. If sufficient DSH funds are not available to fully fund interim hospital-specific limits, each hospital's funding is adjusted pro rata within the DSH funds available under federal law as described in (A).

**Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)**

**Calculating a hospital-specific limit (continued)**

(3) Other non-state hospitals. HHSC will distribute any remaining DSH funds to other qualifying hospitals. HHSC will distribute the remaining funds to the other non-state hospitals based on their individual interim hospital-specific limits and the weighting factors assigned each type of qualifying hospital in section (f)(4).

(4) Weighting factors. All MSA population data that are used to determine the weighting factors are from the most recent decennial census.

(A) Children's hospitals are weighted at 1.25 because of the special nature of the services they provide.

(B) Hospitals with more than 250 licensed beds, associated with hospital districts in the state's largest MSAs, will receive weights based proportionally on the MSA population. The specific weights for these hospitals are as follows:

(i) MSAs with populations greater than or equal to 121,000 and less than 300,000 are weighted at 2.5.

(ii) MSAs with populations greater than or equal to 300,000 and less than 1,000,000 are weighted at 2.75.

(iii) MSAs with populations greater than or equal to 1,000,000 and less than 3,000,000 are weighted at 3.0.

(iv) MSAs with populations greater than or equal to 3,000,000 are weighted at 3.5.

(C) The weighting factor for all other hospitals is 1.0.

**Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)**

**Distribution of available DSH funds (continued)**

(D) HHSC may change the weights as needed in the DSH program to address changes in program size.

(5) Allocation of DSH funds to non-state urban and rural hospitals.

(A) HHSC will divide the amount determined in (f)(3) into two parts:

(i) One-half of the funds will reimburse each qualifying hospital by its percent of the total inpatient Medicaid days.

(ii) One-half of the funds will reimburse each qualifying hospital by its percent of low income days.

(B) After applying (A), HHSC will test to determine whether qualifying hospitals in rural areas will receive 5.5 percent or more of the funds determined in (f)(3).

(i) If hospitals in rural areas receive at least 5.5 percent of the funds, HHSC will reimburse them as calculated in (A) of this section.

(ii) If hospitals in rural areas will not receive at least 5.5 percent of the funds, HHSC will allocate 5.5 percent of the funds in (f)(3) for reimbursement of such hospitals. After the reallocation of funds to meet the 5.5 percent test, HHSC will determine payment amounts to each urban and rural hospital, as described in (A).

(6) DSH distribution methodology for non-state hospitals.

(A) HHSC will calculate the number of weighted total Medicaid inpatient days and weighted low-income days for each qualifying hospital as described in (4).

**Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)**

**Distribution of available DSH funds (continued)**

(B) Using the results obtained under (A), HHSC will calculate each qualifying hospital's annual DSH payment based on the following formula:

((1/2 x available DSH funds) x [(hospital's Medicaid days x weight)/(total weighted Medicaid days)])

+

((1/2 x available DSH funds) x [(hospital's low income days x weight)/(total weighted low income days)]))

(C) HHSC will compare the projected payment for each qualifying hospital with its interim hospital-specific limit. If the hospital's projected payment is greater than its interim hospital-specific limit, HHSC will reduce the hospital's payment to its interim hospital-specific limit.

(D) If there are funds remaining out of the total available DSH funds because some hospitals have had their DSH payments reduced to their interim hospital-specific limits, HHSC will distribute the excess funds to qualifying hospitals that had projected payments below their interim hospital-specific limits as follows. HHSC will:

(i) Calculate the difference between a hospital's interim hospital-specific limit and its projected DSH payment;

(ii) Add all of the differences from (i);

(iii) Calculate a ratio for each hospital by dividing the difference from (i) by the sum from (ii); and

(iv) Multiply the ratio from (iii) by the remaining available DSH funds.

**Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)**

**Distribution of available DSH funds (continued)**

(7) Reallocating funds if a hospital closes, loses its license or eligibility. If a hospital that is receiving DSH funds closes, loses its license, or loses its Medicare or Medicaid eligibility during a DSH program year, HHSC will reallocate that hospital's disproportionate share funds going forward among all DSH providers that are eligible for additional payments.

(8) Hospital located in a federal natural disaster area. If a hospital is located in a county that is declared a federal natural disaster area, it may request that the state use the hospital's data from the most recent years prior to the natural disaster to meet the state's disproportionate share hospital qualification criteria and conditions of participation for the current DSH program. Data used to calculate the hospital's qualification and payment limitations set forth in sections 1923(d)(3) and 1923(g) of the Social Security Act must come from the same year's data as would otherwise be used to calculate payments for the current DSH program year.

(g) Recovery of DSH funds. Notwithstanding any other provision of this section, HHSC will recoup any overpayment of DSH funds made to a hospital, including an overpayment that results from HHSC error or that is identified in an audit. These funds will be redistributed proportionately to DSH providers that are eligible for additional payments.

(h) Audit process.

(1) Independent certified audit. HHSC is required by the Social Security Act to annually complete an independent certified audit of each hospital participating in the DSH program in Texas. Audits will comply with all applicable federal law and directives, including the Act, the Omnibus Budget and Reconciliation Act of 1993 (OBRA '93), the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), pertinent federal rules, and any amendments to such provisions.

(A) Each audit report will contain the verifications set forth in 42 CFR §455.304(d).

**Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)**

**Audit process (continued)**

(B) The sources of data utilized by HHSC, the hospitals, and the independent auditors to complete the DSH audit and report include:

(i) The Medicaid cost report;

(ii) Medicaid Management Information System data; and

(iii) Hospital financial statements and other auditable hospital accounting records.

(C) A hospital must provide HHSC or the independent auditor with the necessary information in the time specified by HHSC or the independent auditor. A complete detailed listing of all information required by the independent auditor is available on the HHSC's internet website.

(D) A hospital that fails to provide requested information or to otherwise comply with the independent certified audit requirements may be subject to a withholding of Medicaid disproportionate share payments or other appropriate sanctions.

(E) HHSC will recoup any overpayment of DSH funds made to a hospital that is identified in the independent certified audit and will redistribute the recouped funds proportionately to DSH providers that are eligible for additional payments subject to their final hospital-specific limits.

(2) HHSC may conduct or require additional audits.