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State/Territory Name: Texas

State Plan Amendment (SPA) #: 12-20 NIRT

This file contains the following documents in the order listed:

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

CENTERS FOR MEDICARE & MEDICAID SERVICES

Center for Medicaid and CHIP Services

OCT 19 2012

Mr. Chris Traylor
Deputy Executive Commissioner for Health Services
Health and Human Services Commission
Post Office Box 13247
Mail Code: H100
Austin, Texas 78711

RE: TN 12-20

Dear Mr. Traylor:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 12-20. This amendment updates the administrative practices, definitions, and procedures for State and Non-State Disproportionate Share Hospitals (DSH).

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 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 the assurances provided, Medicaid State plan amendment 12-20 is approved effective February 15, 2012. We are enclosing the CMS-179 and the amended plan pages.

If you have any questions, please call Tamara Sampson at (214) 767-6431.

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: **12-020**

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: **February 15, 2012**

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:
Section 1923 of the Act

7. FEDERAL BUDGET IMPACT: SEE ATTACHMENT
a. FFY **2012** **$0**
b. FFY **2013** **$0**
c. FFY **2014** **$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 proposed amendment codifies existing administrative practices, updates population data, and further modifies state plan language to reflect changes required by the Centers for Medicare and Medicaid Services' (CMS) final rule, Medicaid Program; Disproportionate Share Hospital Payments (CMS-2198-F), published on December 19, 2008 (73 *Federal Register* 77904). The amendment also standardizes definitions and procedures for state and non-state disproportionate share hospitals.

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:
March 30, 2012

16. RETURN TO:
Billy R. Millwee
State Medicaid Director
Post Office Box 13247, MC: H-100
Austin, Texas 78711

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 30 March, 2012

18. DATE APPROVED: OCT 19 2012

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
FEB 15 2012

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 Number 12-020

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 10-062)
Page 2	Page 2 (TN 10-062)
Page 3	Page 3 (TN 10-062)
Page 4	Page 4 (TN 10-062)
Page 5	Page 5 (TN 10-062)
Page 6	Page 6 (TN 10-062)
Page 7	Page 7 (TN 10-062)
Page 8	Page 8 (TN 10-062)
Page 9	Page 9 (TN 10-062)
Page 10	Page 10 (TN 10-062)
Page 11	Page 11 (TN 10-062)
Page 12	Page 12 (TN 10-062)
Page 13	Page 13 (TN 10-062)
Page 14	Page 14 (TN 10-062)
Page 15	Page 15 (TN 10-062)
Page 16	Page 16 (TN 10-062)
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Page 18	Page 18 (TN 10-062)
Page 19	Page 19 (TN 10-062)

Disproportionate Share Hospital (DSH) Reimbursement Methodology

(a) Introduction. Hospitals participating in the Texas Medical Assistance (Medicaid) program that meet the conditions of participation and that serve a disproportionate share of low-income patients are eligible for reimbursement from the disproportionate share hospital (DSH) fund. HHSC will establish each hospital's eligibility for and amount of reimbursement using the methodology described in this section.

(b) Definitions.

(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 nonpayment on behalf of an individual who has third-party coverage.

(4) Centers for Medicare and Medicaid Services (CMS) – The federal agency within the United States Department of Health and Human Services responsible for overseeing and directing Medicare and Medicaid.

(5) 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.

(6) 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.

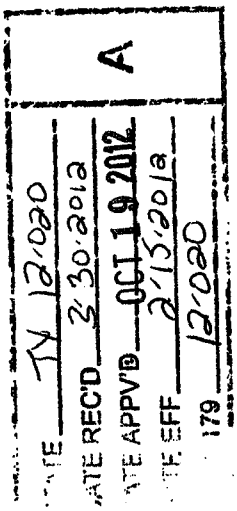
Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)

Definitions (continued)

(7) 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.

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

(9) DSH data year – A twelve-month period, two years before the DSH program year, from which HHSC will compile data to determine DSH program qualification and payment.



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

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

(12) HHSC – The Texas Health and Human Services Commission or its designee.

(13) 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.

Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)

Definitions (continued)

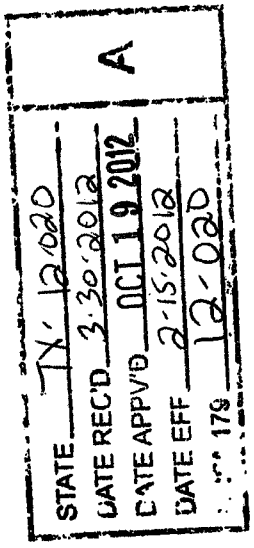
(B) A final hospital-specific limit will be calculated using actual DSH program year cost and payment data.

(14) 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.

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

(16) Inflation update factor – Cost-of-living index based on the annual CMS Prospective Payment System Hospital Market Basket Index.

(17) 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.



(18) Inpatient revenue – Amount of gross inpatient revenue 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 nonhospital revenue, and revenue not identified by the hospital.

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

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

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

Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)

Definitions (continued)

(22) Mean Medicaid inpatient utilization rate – The average of Medicaid inpatient utilization rates for all hospitals that have received a Medicaid payment for an inpatient claim, other than a claim for a dually eligible patient that was adjudicated during the relevant DSH data year.

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

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

(25) Medicaid hospital – A hospital meeting the qualifications to participate in the Texas Medical Assistance program, as determined by the agency listed on page 43 of the Basic State Plan (relating to provider participation requirements).

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

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

(28) Medicaid state plan rate year – The twelve-month period corresponding to the DSH program year, defined in subsection (b).

(29) MSA– Metropolitan Statistical Area as defined by the United States Office of Management and Budget. MSAs with populations greater than or equal to 137,000, according to the most recent decennial census, are considered "the largest MSAs."

(30) 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.

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

Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)

Definitions (continued)

(32) PMSA– Primary Metropolitan Statistical Area as defined by the United States Office of Management and Budget.

(33) Ratio of cost-to-charges (inpatient only) – A 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.

(34) 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 is used in calculating the hospital-specific limit and does not distinguish between payer types such as Medicare, Medicaid, or private pay.

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

(36) 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.

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

(38) 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.

(39) Total Medicaid inpatient days – Total number of inpatient days based on adjudicated claims data for covered services for the relevant DSH data year.

(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;

Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)

Definitions (continued)

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

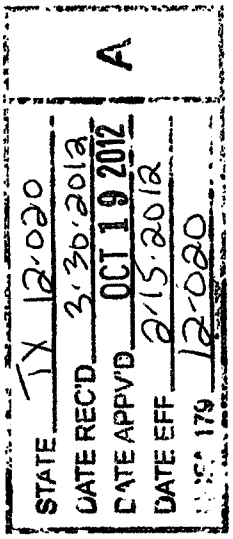
(v) days for dually eligible patients for purposes of the calculation in (c)(1).

(B) The term excludes:

(i) days attributable to Medicaid-eligible patients between the ages of 21 and 64 in an IMD;

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

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



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

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

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

(41) Total state and local payments– 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. The term excludes payment sources that include federal dollars and contractual discounts and allowances.

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

Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)

Definitions (continued)

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

(44) Urban hospital – A hospital located inside a MSA or PMSA.

(45) Waiver – Refers to certain supplemental programs authorized under the Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver that was approved by CMS on December 12, 2011.

(46) 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.

(47) 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, , 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 total 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.

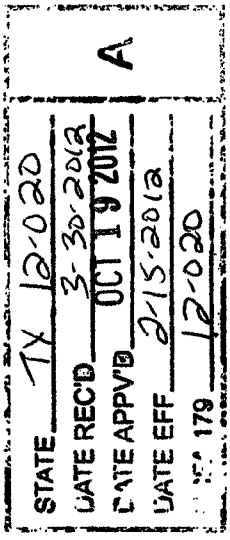
(B) Urban hospital: An urban hospital must have a Medicaid inpatient utilization rate that is at least one standard deviation above the mean Medicaid inpatient utilization rate for all Medicaid hospitals.

Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)

Qualification (continued).

(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:



(i) The sum of the total Medicaid inpatient hospital payments and the total state and local payments 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 Payments)/(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.

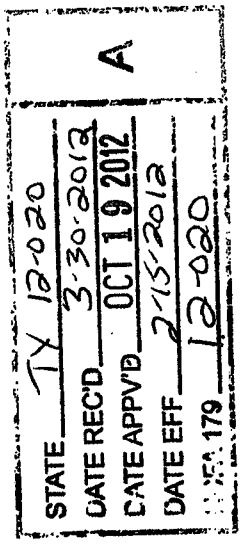
(B) HHSC will determine the ratio of cost-to-charges (inpatient only) by using information from the appropriate worksheets of each hospital's Medicaid cost report or reports that correspond to the DSH data year. In the absence of a Medicaid cost report for that period, HHSC will use the latest available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

(3) Total Medicaid inpatient days.

(A) A hospital must have total Medicaid inpatient days at least one standard deviation above the mean total 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 290,000 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 total Medicaid inpatient days for all 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, state-owned teaching hospitals, and state chest hospitals. Children's hospitals, state-owned teaching hospitals, and state chest 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. HHSC will require each hospital will to meet and continue to meet for each DSH program year the following conditions of participation:

(1) Two-physician requirement.

(A) In accordance with Social Security Act §1923(e)(2), 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 nonemergency obstetrical services to individuals who are entitled to medical assistance for such services.

(B) Subparagraph (A) of this paragraph does not apply if the hospital:

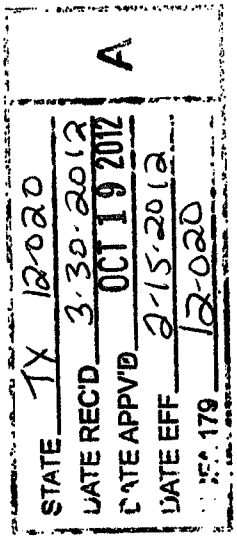
(i) Serves inpatients who are predominately under 18 years of age; or

Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)

Conditions of participation (continued)

(ii) Was operating but did not offer nonemergency obstetrical services as of December 22, 1987.

(C) A hospital must certify on the DSH application that it meets the conditions of either subparagraph (A) or (B), as applicable, at the time the DSH application is submitted.



(2) Medicaid inpatient utilization rate. At the time of qualification and during the DSH program year, a hospital must have a Medicaid inpatient utilization rate, as calculated in subsection (c)(1), of at least one percent.

(3) Retention of and access to records. A hospital must retain and make available to HHSC and its designee records and accounting systems related to DSH data for at least five years from the start of each DSH program year in which the hospital qualifies or until an open audit is completed, whichever is later.

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

(5) Merged hospitals. If HHSC receives the CMS tie-in notice prior to the deadline for submission of the DSH application, the merged entity must meet all conditions of participation. If HHSC does not receive the CMS tie-in notice prior to the deadline for submission of the DSH application, any proposed merging hospitals that are receiving DSH payments must continue to meet all conditions of participation as individual hospitals to continue receiving DSH payments for the remainder of the DSH program year.

(e) Calculating a hospital-specific limit. Using information from each hospital's DSH application and HHSC's Medicaid contractors, HHSC annually will determine the interim hospital-specific limit for each hospital applying for DSH funds in compliance with paragraphs (1) - (3) of this subsection. HHSC will also determine the final hospital-specific limit in compliance with paragraph (4) of this subsection.

Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)

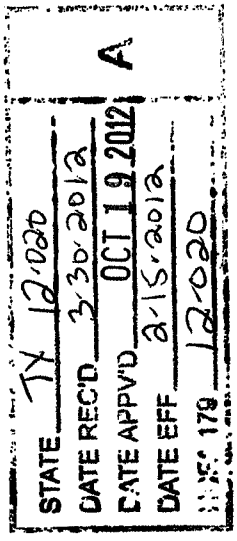
Calculating a hospital-specific limit (continued)

(1) HHSC will calculate a hospital's interim hospital-specific limit by adding the hospital's net uninsured costs for the DSH data year and its Medicaid shortfall for the DSH data year, 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 for services that would be covered by Medicaid that were provided to uninsured patients discharged during the DSH data year. In addition to the charges in the previous sentence, an IMD may report charges for services that would be covered by Medicaid that were provided during the DSH data year to Medicaid eligible patients between the ages of 21 and 64.



(ii) Each hospital will report in its DSH application all payments received for services that would be covered by Medicaid and that are provided to uninsured patients discharged 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 as described in subclause (II) of this clause;

Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)

Calculating a hospital-specific limit (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 paragraph (3) of this subsection.

(iv) HHSC will subtract all payments received under clause (ii) of this subparagraph from the uninsured costs under clause (iii) of this subparagraph, 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 charges and payments for:

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

(-b-) Claims or portions of claims that were not paid because they exceeded the spell-of-illness limitation; and

(II) HHSC will exclude charges and payments for:

Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)

Calculating a hospital-specific limit (continued)

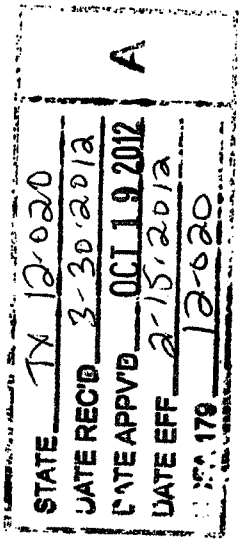
(-a-) Claims for services not covered by Medicaid, including

(-1-) Claims from the Children's Health Insurance Program; and

(-2-) Inpatient claims associated with the Women's Health Program; and

(-b-) Claims submitted after the 95-day filing deadline.

(ii) Upon receipt of the requested data from the Medicaid contractors, 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 paragraph (3) of this subsection.

(iv) HHSC will subtract each hospital's Medicaid payments, including cost report settlement payments, supplemental 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 paragraph (1) of this subsection.

(vi) If a rebasing or other change in reimbursement rate that occurred after the data year will result in an overpayment or underpayment to participating hospitals, HHSC will apply an adjustment factor to the Medicaid payment data to more accurately approximate the Medicaid shortfall.

Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)

Calculating a hospital-specific limit (continued)

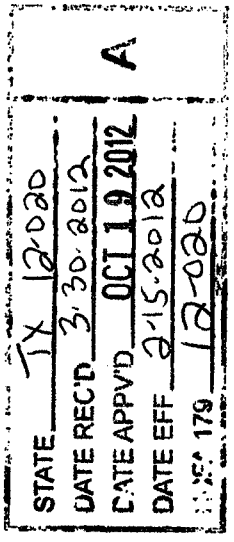
(C) Inflation adjustment.

(i) HHSC will trend each hospital's hospital-specific limit using the inflation update factor as defined in subsection (b) of this section.

(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.

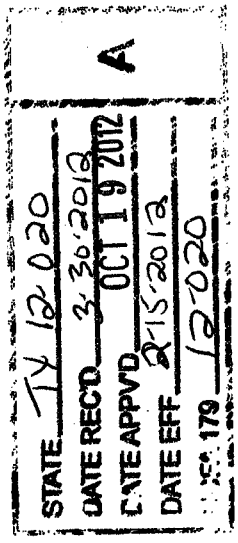
(B) HHSC will calculate the ratio of cost-to-charges for the respective cost centers using information from the appropriate worksheets of the hospital's Medicaid cost report or reports corresponding to the DSH data year. In the absence of a Medicaid cost report for that period, the hospital will submit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

Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)

Calculating a hospital-specific limit (continued)

(4) Final hospital-specific limit.



(A) HHSC will calculate the individual components of a hospital's final hospital-specific limit using the calculation set out in paragraphs (2) and (3) of this subsection, except that HHSC will:

(i) Use the hospital's actual charges and payments for services provided to Medicaid-eligible and uninsured patients during the DSH program year; and

(ii) Include charges and payments for claims submitted after the 95-day filing deadline for Medicaid-allowable services provided during the program year unless such claims were submitted after the Medicare filing deadline.

(B) The final hospital-specific limit will be calculated at the time of 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.

Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)

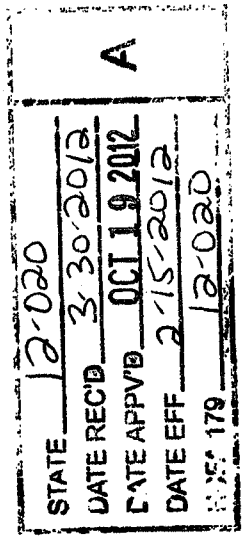
Distribution of available DSH funds (continued)

(B) An IMD that satisfies the DSH requirements will receive 100 percent of its interim hospital–specific limit within the limits described in subparagraph (A) of this paragraph. If sufficient DSH funds for IMDs are not available to fully fund all IMDs to their interim hospital-specific limits, HHSC will pay all IMDs proportionately based on each IMD's percentage of the total interim hospital-specific limit for all IMDs.

(3) Other non-state hospitals. HHSC distributes the remaining DSH funds, if any, to other qualifying hospitals. The available DSH funds for the remaining hospitals equal the lesser of the funds remaining in the state's annual disproportionate share allotment or the sum of qualifying hospitals' interim hospital-specific limits.

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

(A) Children's hospitals are weighted at 2.50 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 137,000 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 subsection (f)(3) of this section into two parts:

(i) One-half of the funds will reimburse each qualifying hospital by its percent of the aggregate 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 clause (A) of this subparagraph, HHSC will test to determine whether qualifying hospitals in rural areas will receive 5.5 percent or more of the funds determined in subsection (f)(3) of this section.

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

(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 subsection (f)(3) of this section 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 clause (A) of this subparagraph.

(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 paragraph (4) of this subsection.

Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)

Distribution of available DSH funds (continued)

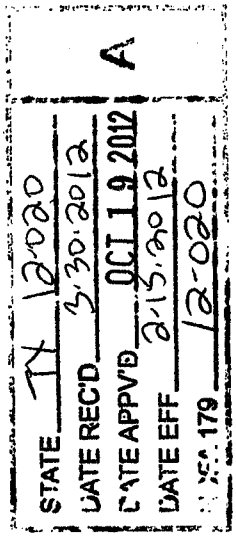
(B) Using the results obtained under subparagraph (A) of this paragraph, HHSC will calculate each qualifying hospital's annual DSH payment based on the following formula:

((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 clause (i) of this subparagraph;

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

(iv) Multiply the ratio from clause (iii) of this subparagraph by the remaining available DSH funds.

(E) Each hospital's total DSH payment (including the redistribution of excess funds) may not exceed its interim hospital-specific limit.

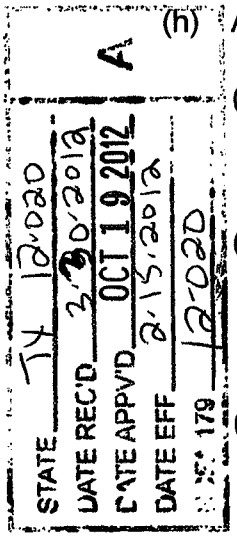
Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)

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 and that was participating in the DSH program at the time of the natural disaster may request that HHSC determine its DSH qualification and interim reimbursement payment amount under this subsection for subsequent DSH program years. The final hospital specific limit will be computed based on the actual data for the 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. Recovered 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.

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

(3) 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.