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State/Territory Name: Texas

State Plan Amendment (SPA) #: 12-39 NIRT

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form
- 3) Superseding Page Listing
- 4) Approved SPA Pages

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



Center for Medicaid and CHIP Services

DEC 19 2012

Ms. Kay Ghahremani
State Medicaid/CHIP Director
Health and Human Services Commission
Post Office Box 13247
Mail Code: H100
Austin, Texas 78711

RE: TN 12-39

Dear Ms. Ghahremani:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 12-39. This amendment changes the methodology for the distribution of Disproportionate Share Hospitals (DSH) reimbursements for specific categories of hospitals. Additionally, the amendment updates page for consistency and renumber lists.

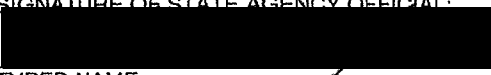

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a) and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. As part of the review process the State was asked to provide information regarding funding of the State share of expenditures under Attachment 4.19-A. Based upon the assurances provided, Medicaid State plan amendment 12-39 is approved effective September 24, 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,

Cindy Mann
Director
Center for Medicaid and CHIP Services

Enclosures

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES		1. TRANSMITTAL NUMBER: 12-039	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: September 24, 2012	
5. TYPE OF PLAN MATERIAL (Circle One): <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> 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 changes the methodology for the distribution of DSH reimbursements for specific categories of hospitals. The amendment also updates pages for consistency and rennumbers lists.			
11. GOVERNOR'S REVIEW (Check One): <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input checked="" type="checkbox"/> OTHER, AS SPECIFIED: Sent to Governor's Office this date. Comments, if any, will be forwarded upon receipt. <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO: Chris Traylor State Medicaid Director Post Office Box 13247, MC: H-100 Austin, Texas 78711	
13. TYPED NAME: Chris Traylor			
14. TITLE: State Medicaid Director			
15. DATE SUBMITTED: September 28, 2012			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: 28 September, 2012		18. DATE APPROVED: DEC 19 2012	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: 24 September, 2012		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: Penny Thompson		22. TITLE: Deputy Director, CMCS	
23. REMARKS:			

Attachment to Blocks 8 & 9 to CMS Form 179

Transmittal Number 12-039

**Number of the
Plan Section or Attachment**

Appendix 1 to Attachment 4.19-A

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**Number of the Superseded
Plan Section or Attachment**

Appendix 1 to Attachment 4.19-A

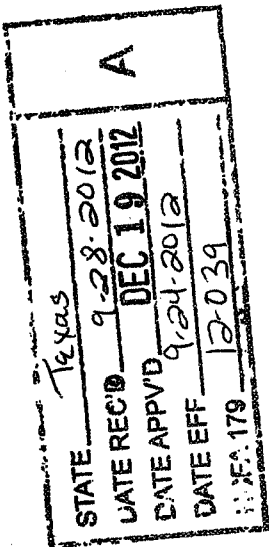
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Disproportionate Share Hospital (DSH) Reimbursement Methodology

(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 total amount of funds that may be distributed to eligible qualifying DSH hospitals during the DSH program year, based on the federal DSH allotment for Texas and available non-federal funds.
- (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.



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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 (DSH) – A hospital identified by HHSC that meets the DSH program conditions of participation and that serves a disproportionate share of Medicaid 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.
 - (11) Dually eligible patient – A patient who is simultaneously eligible for Medicare and Medicaid.
 - (12) Governmental entity – a state agency or political subdivision of the state. A governmental entity includes a hospital authority, hospital district, city, county or state entity.
 - (13) HHSC – The Texas Health and Human Services Commission or its designee.
 - (14) Hospital-specific limit – The maximum payment amount during a program year that a hospital may receive in reimbursement for the cost of providing Medicaid-allowable services to individuals who are Medicaid eligible or uninsured. The term does not apply to payment for costs of providing services to individuals who have third-party coverage.
- (A) Interim hospital-specific limit. Applies to payments that will be made during the DSH program year and is calculated using cost and payment data from the data year.

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

- (B) Final hospital-specific limit. Applies to payments made during a prior DSH program year and is calculated using actual cost and payment data from that period.
- (15) 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.
- (16) Indigent individual – An individual classified by a hospital as eligible for charity care.
- (17) Inflation update factor – Cost-of-living index based on the annual CMS prospective payment system hospital market basket index.
- (18) 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.
- (19) 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.
- (20) Institution for mental disease (IMD) – A hospital that is primarily engaged in providing psychiatric diagnosis, treatment, or care of individuals with mental illness.
- (21) Low-income days – Number of inpatient days attributed to indigent patients.
- (22) Low-income utilization rate – A DSH qualification criterion calculated as described in subsection (c)(2).

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

- (23) 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.
- (24) Medicaid contractor – Fiscal agents and managed care organizations with which HHSC contracts to process data related to the Medicaid program.
- (25) Medicaid cost report – *Hospital and Hospital Health Care Complex Cost Report*, also known as the Medicare cost report.
- (26) 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).
- (27) Medicaid inpatient utilization rate – A DSH qualification criterion calculated as described in (c)(1).
- (27) Medicaid shortfall – The unreimbursed cost of Medicaid inpatient and outpatient hospital services furnished to Medicaid patients.
- (28) 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."
- (29) 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.
- (30) Outpatient charges – Amount of gross outpatient charges related to the applicable DSH data year and used in the calculation of the Medicaid shortfall.

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

- (31) PMSA– Primary Metropolitan Statistical Area as defined by the United States Office of Management and Budget.
- (32) Public funds – Funds derived from taxes, assessments, levies, investments, and other public revenues within the sole and unrestricted control of a governmental entity. Public funds do not include gifts, grants, trusts, or donations, the use of which is conditioned on supplying a benefit solely to the donor or grantor of the funds.
- (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 hospital – A hospital located 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.

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

- (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) 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 ages 21 through 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).

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- (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 and outpatient 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.

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

- (43) Urban hospital – A hospital located inside a MSA or PMSA.
- (44) Urban public hospital – An urban hospital that is owned or under a lease contract with one of the following entities: the Dallas County Hospital District, the Ector County Hospital District, the El Paso County Hospital District, the Harris County Hospital District, the Lubbock County Hospital District, the Tarrant County Hospital District, Central Health District of Travis County, or the University Health System of Bexar County.
- (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.

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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 (2)(A)(i) and (ii):
- (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;

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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 (c)(3).
- (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 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) The requirement in (d)(1)(A) does not apply if the hospital:
 - (i) Serves inpatients who are predominately under 18 years of age; or

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Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)
Conditions of participation (continued)

- (iii) 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 (d)(1)(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 (c)(1), of at least one percent.
- (3) Trauma system.
- (A) The hospital must be in active pursuit of designation or have obtained a trauma facility designation as defined in the Texas Health and Safety Code. A hospital that has obtained its trauma facility designation must maintain that designation for the entire DSH program year.
- (B) HHSC will receive an annual report from the Office of EMS/Trauma Systems Coordination regarding hospital participation in regional trauma system development, application for trauma facility designation, and trauma facility designation or active pursuit of designation status before final qualification determination for interim DSH payments. HHSC will use this report to confirm compliance with this condition of participation by a hospital applying for DSH funds.
- (4) 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.

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Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)
Conditions of participation (continued)

- (5) Compliance with audit requirements. A hospital must agree to comply with the audit requirements described in (i).
- (6) 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 from HHSC's Medicaid contractors, 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 compliance with (e)(4).

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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 Medicaid allowable services that were provided during the DSH data year to Medicaid eligible and uninsured patients ages 21 through 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 section, 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 (e)(2)(A)(ii)(II);

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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 (e)(3).
- (iv) HHSC will subtract all payments received under (e)(2)(A)(ii) from the uninsured costs under (e)(2)(A)(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 charges and payments for:

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

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

- (II) HHSC will exclude charges and payments for:

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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 (e)(3).

(iv) HHSC will subtract each hospital's Medicaid payments, including cost report settlement payments, upper payment limit payments, uncompensated-care waiver payments (excluding payments associated with pharmacies, clinics, and physicians), and graduate medical education payments, from its Medicaid costs and apply cost settlements (payments or recoupments) applicable to the DSH data year.

(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).

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Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)
Calculating a hospital-specific limit (continued)

- (vi) HHSC will apply an adjustment factor to the Medicaid payment data to more accurately approximate the Medicaid shortfall 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.

(C) Inflation adjustment.

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

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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 (e)(2) and (e)(3), 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 (i).

(f) Distribution of available DSH funds. Before the start of each DSH program year, CMS publishes the federal DSH allotment for each state. HHSC will distribute the available DSH funds as defined in (b)(2) among eligible, qualifying DSH 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 less than or equal to their interim hospital-specific limits.

(2) IMDs.

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

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Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)
Distribution of available DSH funds (continued)

(B) State-owned IMDs.

- (i) From the amount determined in (f)(2)(A), HHSC will deduct the amount of the Non-State-Owned IMD Pool determined in (f)(2)(C)(i) to derive the amount available for distribution to state-owned IMDs.
- (ii) A state-owned IMD that satisfies the DSH requirements will receive 100 percent of its interim hospital-specific limit within the amount determined in (f)(2)(B)(i). If the amount described in (f)(2)(B)(i) is not sufficient to fully fund all state-owned IMDs to their interim hospital-specific limits, HHSC will pay all such IMDs proportionately based on each IMD's percentage of the total interim hospital-specific limit for all such IMDs.

(C) Non-state-owned IMDs.

- (i) The aggregate amount available for distribution to non-state-owned IMDs (the Non-State-Owned IMD Pool) is limited to 1.88% of the amount described in (f)(2)(A).
- (ii) Payment to each non-state-owned IMD will be proportionately reduced:
 - (I) to stay within the limitations described in (f)(C)(i); or
 - (II) if a governmental entity does not transfer sufficient intergovernmental transfer funds (IGT) to fund all non-state-owned IMDs to the amount described in (f)(C)(i).
- (iii) For DSH program year 2012, the amount of the Non-State-Owned IMD pool determined in (f)(C)(i) for all non-state-owned IMDs has already been paid, so non-state-owned IMDs will not receive additional DSH payments for the program year.

- (3) Other non-state hospitals. HHSC distributes the remaining available DSH funds, if any, to other qualifying hospitals using the methodology described in (g). The remaining available DSH funds equal the lesser of the funds as defined in (b)(2) less funds expended under (f)(1) and (2) or the sum of remaining qualifying hospitals' interim hospital-specific limits.

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Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)

(g) DSH payment calculation.

(1) Medicaid data verification.

- (A) On or about April 15 of each year, and upon request, HHSC will make available to each Medicaid participating hospital a report of the hospital's adjudicated data received from Medicaid contractors reflecting the hospital's Medicaid days, Medicaid charges, and Medicaid payments during the DSH data year.
- (B) A hospital must communicate directly with the appropriate Medicaid contractors to request correction of any data the hospital believes is inaccurate or incomplete.
- (C) Each Medicaid contractor will submit a final report to HHSC by July 15 of each year or a date specified by HHSC, which will include all agreed upon corrections resulting from requests submitted by hospitals. Unless a hospital contacts HHSC pursuant to (g)(1)(D), HHSC will use the corrected report for DSH calculations described in this section.
- (D) At a hospital's request, HHSC will review instances in which a hospital and a Medicaid contractor cannot resolve disputes concerning data included in or excluded from the final report. HHSC will make the final determination in such a case and notify the hospital of the final determination.

(2) Allocation of available DSH funds by category of hospital. From the amount of remaining available DSH funds determined in (f)(3), HHSC will establish a pool amount for DSH payments to each of the following categories of hospital:

- (A) Children's hospitals. The amount of the children's hospital pool is 8.36% of the amount determined in (f)(3).
- (B) Rural hospitals. The amount of the rural hospital pool is 5.98% of the amount determined in (f)(3).
- (C) Urban public hospitals. The amount of the urban public hospital pool is 51.25% of the amount determined in (f)(3).

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DSH Payment Calculation (continued)

- (D) Other hospitals. The amount of the pool for all hospitals not described in (g)(2)(A) - (C) is 34.41% of the amount determined in (f)(3).
- (3) HHSC will give notice of the amounts determined in (f)(2)(C)(i) and in (g)(2).
- (4) Distribution and payment calculation methodology for Children's Hospitals, Rural Hospitals, and Other Hospitals.
- (A) For each category of hospital described in (g)(2)(A), (B), and (D), HHSC will divide the amount of the pool into two equal parts:
- (i) One half of the funds will reimburse each hospital in that category based on its percentage of the aggregate Medicaid inpatient days for all hospitals in that category.
 - (ii) One half of the funds will reimburse each hospital in that category based on its percentage of the aggregate low-income days for all hospitals in that category.
- (B) HHSC will calculate each hospital's total Medicaid inpatient days and total low-income days.
- (C) Using the results in (g)(4)(B), HHSC will:
- (i) divide each hospital's total Medicaid inpatient days by the sum of Medicaid inpatient days for all hospitals in the same category to obtain a percentage;
 - (ii) multiply each hospital's percentage calculated in (g)(4)(C)(i) by the amount determined in (g)(4)(A)(i);
 - (iii) divide each hospital's total low-income days by the sum of low-income days for all hospitals in the same category to obtain a percentage;
 - (iv) multiply each hospital's percentage calculated in (g)(4)(C)(iii) by the amount determined in (g)(4)(A)(ii); and

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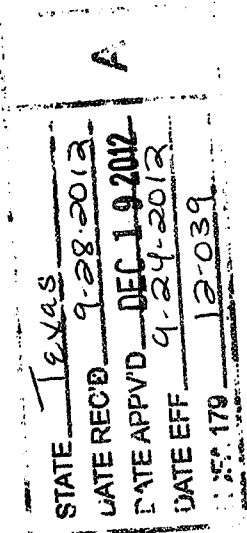
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Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)
DSH Payment Calculation (continued)

- (v) sum the results of (g)(4)(C)(ii) and (iv) to determine each hospital's projected annual payment amount.
- (i) The projected annual payment amount may not exceed a hospital's interim hospital-specific limit.
- (ii) Any amount above a hospital's interim hospital-specific limit will be redistributed to other hospitals as described in (g) (7).
- (5) Payments for urban public hospitals. For the hospitals described in (g)(2)(C), HHSC will reimburse each hospital as described below:
- (A) Dallas County Hospital District - \$191,216,630.54
 - (B) Ector County Hospital District - \$17,518,546.04
 - (C) El Paso County Hospital District - \$33,520,031.59
 - (D) Harris County Hospital District - \$168,676,986.88
 - (E) Lubbock County Hospital District - \$22,327,864.56
 - (F) Tarrant County Hospital District - \$80,196,067.76
 - (G) Central Health District of Travis County - \$25,617,715.06
 - (H) University Health System of Bexar County - \$73,932,316.58
- (6) Reconciliation of 2012 DSH payments. For DSH program year 2012, HHSC will reduce the projected annual payment amount determined in (g)(4)(C)(v) and (g)(5)(C) by the amount of all DSH payments already received by the hospital for the program year to determine a remaining interim payment amount. If the amount of the DSH payments already received equals or exceeds the projected annual payment amount:
- (A) the hospital will not receive additional DSH funds for the program year;



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Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)
DSH Payment Calculation (continued)

- (B) remaining interim DSH payments to remaining hospitals in that category will be reduced as follows. HHSC will:
- (i) sum the remaining interim payment amounts for all such hospitals;
 - (ii) divide each such hospital's remaining interim payment amount by the result of (g)(6)(B)(i);
 - (iii) for each hospital described in (g)(6)(A), subtract the hospital's projected annual payment amount as determined in (g)(4)(C)(v) or (g)(5)(C) as appropriate from the amounts already paid to the hospital. Sum the results of this calculation for all hospitals described in (g)(6)(A);
 - (iv) multiply the result of (g)(6)(B)(ii) for each hospital by the result of (g)(6)(B)(iii); and
 - (v) subtract the result of (g)(6)(B)(iv) from the hospital's remaining interim payment amount to derive a payment amount.

- (7) Redistribution of amounts in excess of hospital-specific limits. In the event that the projected annual payment amount calculated in (g)(4)(C) and (g)(5)(C) exceeds a hospital's interim hospital-specific limit, the payment amount will be reduced to the interim hospital-specific limit. For each category of hospital described in (2), HHSC will separately sum all resulting excess funds and redistribute that amount to qualifying hospitals in that category that have projected payments below their interim hospital-specific limits. For each such hospital, HHSC will:

- (A) subtract the hospital's projected DSH payment from its interim hospital-specific limit;
- (B) sum the results of (g)(7)(A) for all hospitals in the same category; and
- (C) compare the sum from (g)(7)(B) to the total excess funds calculated for the category of hospital

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DSH Payment Calculation (continued)

- (i) If the sum of (g)(7)(B) is less than or equal to the total excess funds, HHSC will pay all such hospitals up to their interim hospital-specific limit and any remaining excess funds will be allocated to the other categories of hospitals described in this subsection.
- (ii) If the sum of (g)(7)(B) is greater than the total excess funds, HHSC will calculate payments to all such hospitals as follows:
 - (i) Divide the result of (g)(7)(A) for each hospital by the sum from (g)(7)(B).
 - (ii) Multiply the ratio from (g)(7)(C)(i) by the sum of the excess funds from all hospitals in the same category.
 - (iii) Add the result of (g)(7)(C)(ii) to the projected DSH payment for that hospital.
- (8) 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 hospitals in the same category that are eligible for additional payments.
- (9) 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, that hospital 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.

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Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)
DSH Payment Calculation (continued)

- (h) 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.
- (i) 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 as described in (e)(4).

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