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State/Territory Name: Texas

State Plan Amendment (SPA) #: 13-42

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 S2-26-12
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

FEB 10 2014

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

RE: TN 13-42

Dear Ms. Ghahremani:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 13-42. This amendment revises the methodology for the distribution of Disproportionate Share Hospitals (DSH) reimbursements and revises the methodology for calculating hospital specific limits.

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 13-42 is approved effective October 4, 2013. 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

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: **13-042**

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 4, 2013**

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 2013** **$0**
b. **FFY 2014** **$0**
c. **FFY 2015** **$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 revises the methodology for the distribution of disproportionate share hospital reimbursements and updates the methodology for calculating the hospital-specific limit.

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:
Kay Ghahremani

14. TITLE:
State Medicaid Director

15. DATE SUBMITTED:
November 14, 2013

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

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: November 14, 2013

18. DATE APPROVED: FEB 10 2014

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
OCT 04 2013

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME:
Penny Thompson

22. TITLE:
Deputy Director, Policy & Financial Mgt. CMCS

23. REMARKS:

FORM CMS – 179 (07-92)

Attachment to Blocks 8 & 9 of CMS Form 179

Transmittal Number 13-042

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 12-039)
Page 2	Page 2 (TN 12-039)
Page 3	Page 3 (TN 12-039)
Page 4	Page 4 (TN 12-039)
Page 5	Page 5 (TN 12-039)
Page 6	Page 6 (TN 12-039)
Page 7	Page 7 (TN 12-039)
Page 8	Page 8 (TN 12-039)
Page 9	Page 9 (TN 12-039)
Page 10	Page 10 (TN 12-039)
Page 11	Page 11 (TN 12-039)
Page 12	Page 12 (TN 12-039)
Page 13	Page 13 (TN 12-039)
Page 14	Page 14 (TN 12-039)
Page 15	Page 15 (TN 12-039)
Page 16	Page 16 (TN 12-039)
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Page 18	Page 18 (TN 12-039)
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Page 20	Page 20 (TN 12-039)
Page 21	Page 21 (TN 12-039)
Page 22	Page 22 (TN 12-039)
Page 23	Page 23 (TN 12-039)
Page 24	N/A - new page
Page 25	N/A - new page
Page 26	N/A - new page

STATE Texas
DATE REC'D 11-14-2013
DATE APPV'D FEB 10 2014
DATE EFF 10-1-2013
TN# 179 13-042

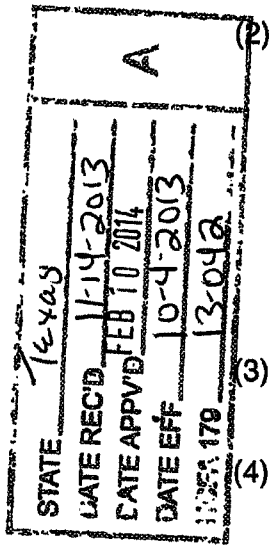
A

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 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 appendix.

(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. HHSC may divide available DSH funds for a program year into one or more portions of funds to allow for partial payment(s) of total available DSH funds at any one time with remaining funds to be distributed at a later date(s). If HHSC chooses to make a partial payment, the available DSH funds for that partial payment are limited to the portion of funds identified by HHSC for that partial payment.

(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.

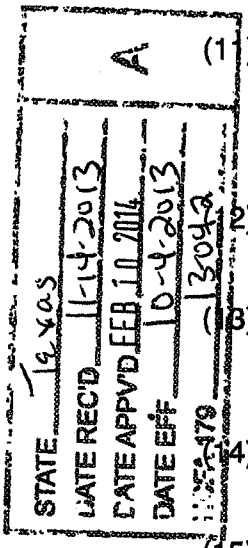
Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)
Definitions (continued)

(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 (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) DSH survey – The HHSC data collection tool completed by each DSH hospital and used by HHSC to calculate the interim and final hospital-specific limit, and to estimate the hospital's DSH payments for the program year.

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

(13) 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.

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

(15) Hospital-specific limit – The maximum payment amount applicable to a DSH 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 non-Medicaid-eligible individuals who have third-party coverage; costs associated with pharmacies, clinics and physicians; or costs associated with Delivery System Reform and Incentive Payment projects.

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

(A) Interim hospital-specific limit. Applies to payments that will be made during the DSH program year and is calculated using interim cost and payment data from the DSH data year.

(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 the DSH program year.

(16) 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.

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

(18) Inflation update factor – Cost-of-living index based on the annual CMS prospective payment system hospital market basket index.

(19) 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.

(20) 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.

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

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

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

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

(24) 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.

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

(26) Medicaid cost-to-charge ratio (inpatient and outpatient) – A Medicaid cost report derived cost center ratio calculated for each ancillary cost center that covers all applicable hospital costs and charges relating to inpatient and outpatient care for that cost center. This ratio is used in calculating the hospital-specific limit and does not distinguish between payer types such as Medicare, Medicaid, or private pay.

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

(28) Medicaid hospital – A hospital meeting the qualifications to participate in the Texas Medicaid program, as determined by the agency listed on page 43 of the basic state plan (relating to provider participation requirements).

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

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

(31) 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."

(32) 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.

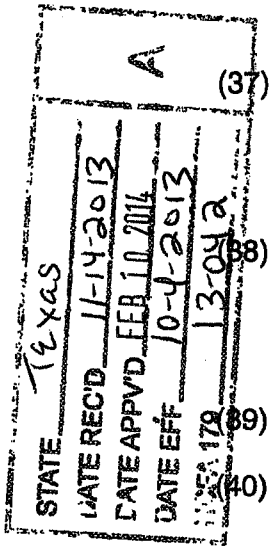
Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)
Definitions (continued)

(33) Outpatient charges – Amount of gross outpatient charges related to the applicable DSH data year and used in the calculation of the hospital specific limit.

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

(35) Program year – The 12-month period beginning October 1 and ending September 30.

(36) 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.



(37) 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.

(38) Regional Healthcare Partnership (RHP) area – A geographic area that corresponds to the geographic area of one of the Regional Healthcare Partnerships described in the Texas Healthcare Transformation and Quality Improvement Program §1115(a) Medicaid demonstration waiver.

(39) Rural hospital – A hospital located outside an MSA or a PMSA.

(40) Rural public hospital – A hospital owned or operated by a governmental entity that is located in a county with 500,000 or fewer persons, based on the most recent decennial census.

(41) Rural public-financed hospital – A hospital operating under a lease from a governmental entity in which the hospital and governmental entity are both located in the same county with 500,000 or fewer persons, based on the most recent decennial census.

(42) State chest hospital – A public health facility operated by the Department

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

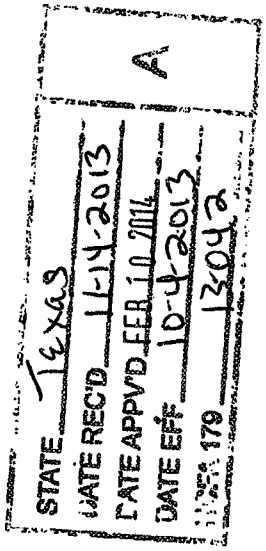
of State Health Services and designated for the care and treatment of patients with tuberculosis.

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

(44) The waiver – The Texas Healthcare Transformation and Quality Improvement Program, a Medicaid demonstration waiver under §1115 of the Social Security Act that was approved by CMS on December 12, 2011.

(45) 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.

(46) 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;
- (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) and (g)(4).

(47) 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

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

hospital received:

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

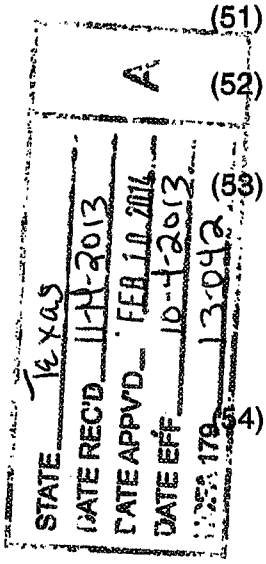
(B) for patients eligible for Medicaid in other states.

(48) 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.

(49) Uncompensated-care waiver payments – Payments to hospitals participating in the waiver that are intended to defray the uncompensated costs of eligible services provided to eligible individuals.

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

(51) Urban hospital – A hospital located inside an MSA or PMSA.



(52) Urban public hospital – Any of the urban public hospitals listed in (b)(53) or (b)(54).

(53) Urban public hospital – Class one – An urban hospital that is owned by or under a lease contract with one of the following entities: the Dallas County Hospital District, the El Paso County Hospital District, the Harris County Hospital District, the Tarrant County Hospital District, the Travis County Healthcare District, or the University Health System of Bexar County.

(54) Urban public hospital – Class two – An urban hospital that is owned by or under a lease contract with one of the following entities: the Ector County Hospital District or the Lubbock County Hospital District.

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

(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, from HHSC, or from HHSC's Medicaid contractors, as specified by HHSC:

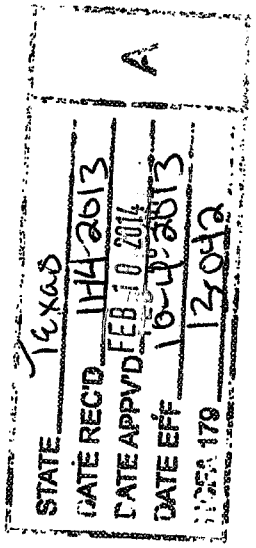
(1) Medicaid inpatient utilization rate. A hospital's inpatient utilization rate is calculated by dividing the hospital's total Medicaid inpatient days by its total inpatient census days for the DSH data year.

(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.

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

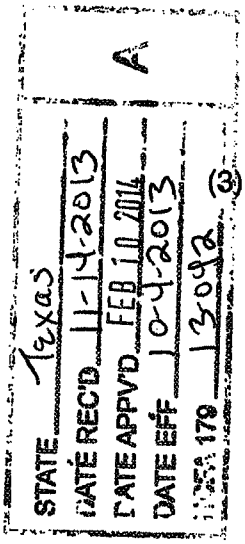
(A) The low-income utilization rate is the sum (expressed as a percentage) of the fractions calculated in (c)(2)(A)(i) and (ii):



(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).

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



(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;

(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 total 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.

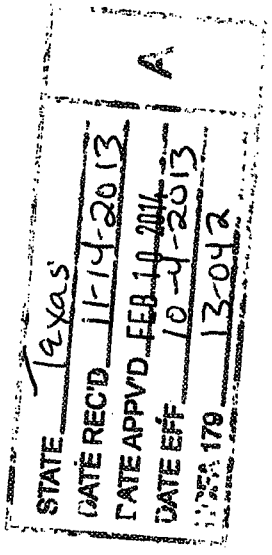
(6) Hospitals that held a single Medicaid provider number during the DSH data year, but later added one or more Medicaid provider numbers. Upon request, HHSC will apportion the Medicaid DSH funding determination attributable to a hospital that held a single Medicaid provider number during the DSH data year (data year hospital), but subsequently added one or more Medicaid provider numbers (new program year hospital(s)) between the data year hospital and its associated new program year

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

hospital(s). In these instances, HHSC will apportion the Medicaid DSH funding determination for the data year hospital between the data year hospital and the new program year hospital(s) based on estimates of the division of Medicaid inpatient and low income utilization between the data year hospital and the new program year hospital(s) for the program year, so long as all affected providers satisfy the Medicaid DSH conditions of participation and qualify as separate hospitals based on HHSC's Medicaid DSH qualification criteria in the applicable Medicaid DSH program year.

(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

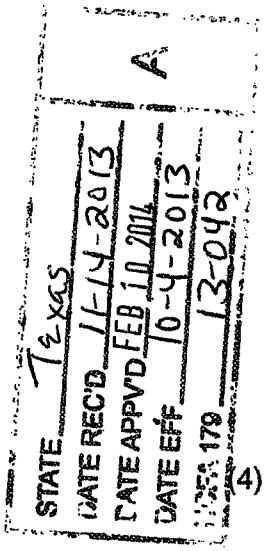
(ii) Was operating but did not offer nonemergency obstetrical services as of December 22, 1987.

(C) A hospital must certify on the DSH application that it meets the conditions of either (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.

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

(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) Maintenance of local funding effort. A hospital district in one of the State's largest MSAs or in a PMSA must not reduce local tax revenues to its associated hospitals as a result of disproportionate share funds received by the hospital. For this provision to apply, the hospital must have more than 250 licensed beds.

(5) 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 end of each DSH program year in which the hospital qualifies or until an open audit is completed, whichever is later.

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

(7) Merged hospitals. If HHSC receives documents verifying the merger status with Medicare 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 documents verifying the merger status with Medicare 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

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

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 survey, Medicaid cost report and from HHSC's Medicaid contractors, HHSC will determine the interim hospital-specific limit for each hospital applying for DSH funds in compliance with (e)(1)(A) - (E). HHSC will also determine the final hospital-specific limit in compliance with (e)(2).

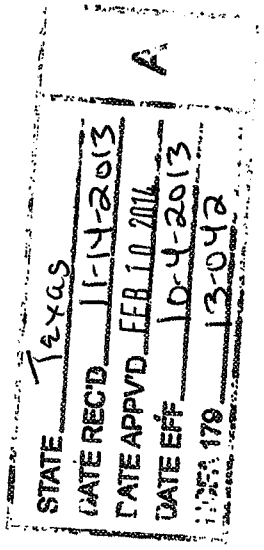
(1) Interim Hospital-Specific Limit

(A) Uninsured charges and payments.

(i) Each hospital will report in its survey 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 survey all payments received during the data year, regardless of when the service was provided, for services that would be covered by Medicaid and were provided to uninsured patients.

(I) For purposes of this paragraph, 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)(1)(A)(ii)(II);



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.

(A) Medicaid charges and payments.

(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.

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

(II) HHSC will exclude charges and payments for:

(-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) HHSC will request from its Medicaid contractors the inpatient and outpatient Medicaid cost settlement payment or recoupment amounts attributable to the cost report period determined in (e)(1)(C)(i).

(iii) Each hospital will report on the survey the inpatient and outpatient Medicaid days, charges and payment data for out-of-state claims adjudicated during the data year.

(iv) HHSC may apply an adjustment factor to Medicaid payment data to more accurately approximate Medicaid payments following a rebasing or other change in reimbursement rates.

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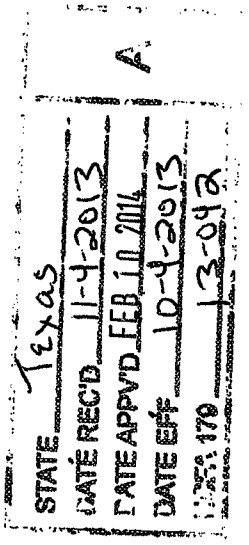
Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)
Calculating a hospital-specific limit (continued)

(C) Calculation of in-state and out-of-state Medicaid and uninsured total costs for the data year.

(i) Cost report period for data used to calculate cost-per-day amounts and cost-to-charge ratios. HHSC will use information from the Medicaid cost report for the hospital's fiscal year that ends during the calendar year that falls two years before the end of the program year for the calculations described in (e)(1)(C)(ii)(I) and (iii)(I). For example, for program year 2013, the cost report year is the provider's fiscal year that ends between January 1, 2011, and December 31, 2011.

(I) For hospitals that do not have a full year cost report that meets this criteria, a partial year cost report for the hospital's fiscal year that ends during the calendar year that falls two years before the end of the program year will be used if the cost report covers a period greater than or equal to six months in length.

(II) The partial year cost report will not be prorated. If the provider's cost report that ends during this time period is less than six months in length, the most recent full year cost report will be used.



(ii) Determining inpatient routine costs.

(I) Medicaid inpatient cost per day for routine cost centers. Using data from the Medicaid cost report, HHSC will divide the allowable inpatient costs by the inpatient days for each routine cost center to determine a Medicaid inpatient cost per day for each routine cost center.

(II) Inpatient routine cost center cost. For each Medicaid payor type and the uninsured, HHSC will multiply the Medicaid inpatient cost per day for each routine cost center from (e)(1)(C)(ii)(I) times the number of inpatient days for each routine cost center from the data year to determine the inpatient routine cost for each cost center.

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

(III)Total inpatient routine cost. For each Medicaid payor type and the uninsured, HHSC will sum the inpatient routine costs for the various routine cost centers from (e)(1)(C)(ii)(II) to determine the total inpatient routine cost.

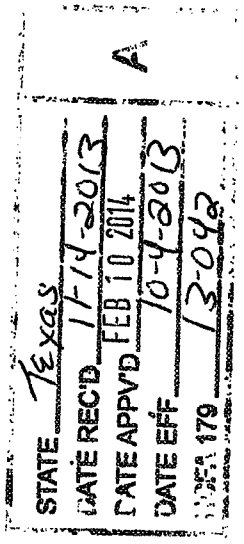
(iii) Determining inpatient and outpatient ancillary costs.

(I) Inpatient and outpatient Medicaid cost-to-charge ratio for ancillary cost centers. Using data from the Medicaid cost report, HHSC will divide the allowable ancillary cost by the sum of the inpatient and outpatient charges for each ancillary cost center to determine a Medicaid cost-to-charge ratio for each ancillary cost center.

(II) Inpatient and outpatient ancillary cost center. For each Medicaid payor type and the uninsured, HHSC will multiply the cost-to-charge ratio for each ancillary cost center from (e)(1)(C)(iii)(I)by the ancillary charges for inpatient claims and the ancillary charges for outpatient claims from the data year to determine the inpatient and outpatient ancillary cost for each cost center.

(III) Total inpatient and outpatient ancillary cost. For each Medicaid payor type and the uninsured, HHSC will sum the ancillary inpatient and outpatient costs for the various ancillary cost centers from (e)(1)(C)(iii)(II)to determine the total ancillary cost.

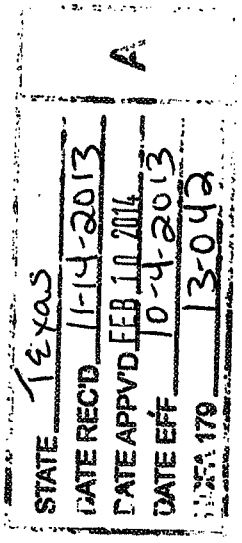
(iv) Determining total Medicaid and uninsured cost. For each Medicaid payor type and the uninsured, HHSC will sum the result of (e)(1)(C)(ii)(III)and the result of (e)(1)(C)(iii)(III) plus organ acquisition costs to determine the total cost.



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

(D) Calculation of the interim hospital-specific limit.

(i) Total hospital cost. HHSC will sum the total cost by Medicaid payor type and the uninsured from (e)(1)(C)(iv) to determine the total hospital cost for Medicaid and the uninsured.



(ii) Interim hospital-specific limit

(I) HHSC will reduce the total hospital cost under (e)(1)(D)(i) by total payments from all payor sources for inpatient and outpatient claims, including but not limited to, graduate medical services and out-of-state payments.

(II) HHSC will not reduce the total hospital cost under (e)(1)(D)(i) by supplemental payments (including upper payment limit payments), or uncompensated-care waiver payments for the data year to determine the interim hospital-specific limit. HHSC may reduce the total hospital cost by supplemental payments or uncompensated-care waiver payments (excluding payments associated with pharmacies, clinics, and physicians) attributed to the hospital for the program year if necessary to prevent total interim payments to a hospital for the program year from exceeding the interim hospital-specific limit for that program year.

(E) Inflation adjustment.

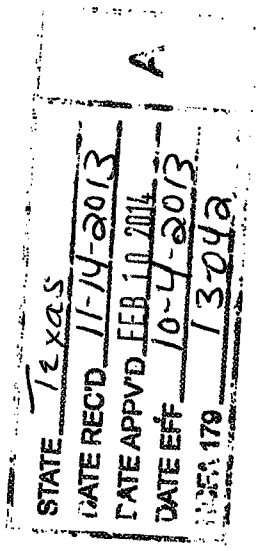
(i) HHSC will trend each hospital's interim hospital-specific limit using the inflation update factor.

(ii) HHSC will trend each hospital's-specific limit from the midpoint of the DSH data year to the midpoint of the DSH program year.

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

(2) 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)(1)(A)-(D), except that HHSC will:



(i) Use information from the hospital's Medicaid cost report(s) that cover the program year and from cost settlement payment or recoupment amounts attributable to the program year for the calculations described in (e)(1)(C)(ii)(I) and (e)(1)(C)(iii)(I). If a hospital has two or more Medicaid cost reports that cover the program year, the data from each cost report will be pro-rated based on the number of months from each cost report period that fall within the program year;

(ii) Include supplemental payments (including upper payment limit payments) and uncompensated-care waiver payments (excluding payments associated with pharmacies, clinics, and physicians) attributable to the hospital for the program year when calculating the total payments to be subtracted form total costs as described in (e)(1)(D)(ii).

(iii) Use the hospital's actual charges and payments for services described in (e)(1)(A) and (B) provided to Medicaid-eligible and uninsured patients during the program year, and

(iv) 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 independent audit conducted under (i).

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

(f) Distribution of available DSH funds. 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, state-owned IMDs, and state chest hospitals. HHSC may reimburse state-owned teaching hospitals, state-owned IMDs, and state chest hospitals an amount less than or equal to their interim hospital-specific limits, except that aggregate payments to IMDs statewide may not exceed federally mandated reimbursement limits for IMDs.

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

(A) Pool One is comprised of urban public hospitals – class two and all hospitals in an RHP area with an urban public hospital – class one. The Pool One amount is equal to a maximum of $794,840,295. If HHSC chooses to make a partial payment, the Pool One amount for that partial payment is limited to the portion of the $794,840,295 identified by HHSC for that partial payment.

(B) Pool Two is comprised of hospitals in RHP areas without an urban public hospital and non-urban public hospitals in RHP areas with an urban public hospital – class two. The Pool Two amount is equal to a maximum of $338,599,754. If HHSC chooses to make a partial payment, the Pool One amount for that partial payment is limited to the portion of the $338,599,754 identified by HHSC for that partial payment.

(2) Weighting factors.

(A) HHSC will assign each urban public hospital a weighting factor based on its RHP area as follows:

(i) RHP Area 3 Urban Public Hospital Weighting Factor is 3.4503.
(ii) RHP Area 6 Urban Public Hospital Weighting Factor is 4.2349.
(iii) RHP Area 7 Urban Public Hospital Weighting Factor is 3.6505.
(iv) RHP Area 9 Urban Public Hospital Weighting Factor is 2.6735.
(v) RHP Area 10 Urban Public Hospital Weighting Factor is 2.6170.
(vi) RHP Area 12 Urban Public Hospital Weighting Factor is 1.7080.
(vii) RHP Area 14 Urban Public Hospital Weighting Factor is 1.7878.
(viii) RHP Area 15 Urban Public Hospital Weighting Factor is 3.2884.

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DSH payment calculation (continued)

(B) All other DSH hospitals not described in (g)(2)(A) will be assigned a weighting factor of 1.0000.

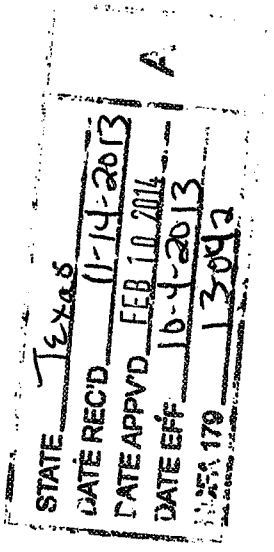
(C) HHSC may change the weighting factors as needed in the DSH program to address changes in program size including changes in the hospital-specific limits of one or more hospitals.

(4) Distribution and payment calculation.

(A) For each category of hospital described in (g)(1)(A) and (B), HHSC will divide the amount of the associated 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 weighted 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 weighted low-income days for all hospitals in that category.



(B) HHSC will calculate each hospital's total weighted Medicaid inpatient days and total weighted low-income days as follows.

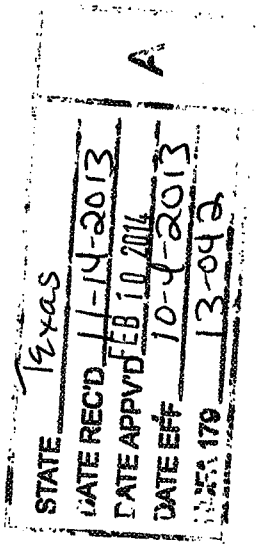
(i) Weighted Medicaid inpatient days are equal to the hospital's Medicaid inpatient days multiplied by the appropriate weighting factor from (g)(2).

(ii) Weighted low-income days are equal to the hospital's low-income days multiplied by the appropriate weighting factor from (g)(2).

(C) Using the results in (g)(4)(B), HHSC will:

(i) divide each hospital's total weighted Medicaid inpatient days by the sum of weighted Medicaid inpatient days for all hospitals in the same category to obtain a percentage;

Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)
DSH payment calculation (continued)



(ii) multiply each hospital's percentage calculated in (g)(4)(C)(i) by the amount determined in (g)(3)(A)(i);

(iii) divide each hospital's total weighted low-income days by the sum of weighted 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) of this subparagraph by the amount determined in (g)(3)(A)(ii); and

(v) sum the results of (g)(4)(C)(ii) and (iv) to determine each hospital's projected payment amount.

(I) The projected 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)(5).

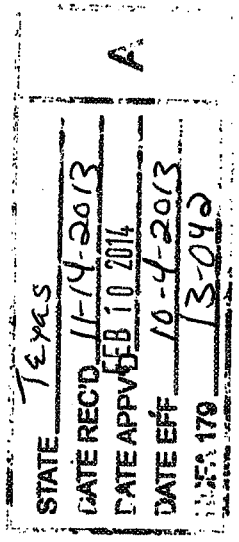
(5) Redistribution of amounts in excess of hospital-specific limits. In the event that the projected payment amount calculated in (g)(4) plus any previous payment amounts for the program year exceeds a hospital's interim hospital-specific limit, the payment amount will be reduced to the interim hospital-specific limit. For each category of hospital described in (g)(1), HHSC will separately sum all resulting excess funds and redistribute that amount to qualifying hospitals in that category that have projected payments, including any previous payment amounts for the program year, below their interim hospital-specific limits. For each such hospital, HHSC will:

(A) subtract the hospital's projected DSH payment plus any previous payment amounts for the program year form its interim hospital-specific limit;

(B) sum the results of (g)(5)(A) for all hospitals in the same category; and

Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)
DSH payment calculation (continued)

(C) compare the sum from (g)(5)(B) to the total excess funds calculated for the category of hospital.



(i) If the sum of (g)(5)(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)(5)(B) is greater than the total excess funds, HHSC will calculate payments to all such hospitals as follows:

(I) Divide the result of (g)(5)(A) for each hospital by the sum from (g)(5)(B).

(II) Multiply the ratio from (g)(5)(C)(ii)(I) by the sum of the excess funds from all hospitals in the same category.

(III) Add the result of (g)(5)(C)(ii)(II)to the projected DSH payment for that hospital to calculate a revised projected payment amount.

(6) Additional allocation of DSH funds for rural public and rural public-financed hospitals. Rural public hospitals or rural public-financed hospitals from either hospitals category in (g)(1) may be eligible for DSH funds in addition to the projected payment amounts calculated in paragraphs (g)(4) and (5).

(A) For each rural public hospital or rural public-financed hospital, determine the projected payment amount plus any previous payment amounts for the program year calculated in accordance with either (g)(4) or (5), as appropriate.

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

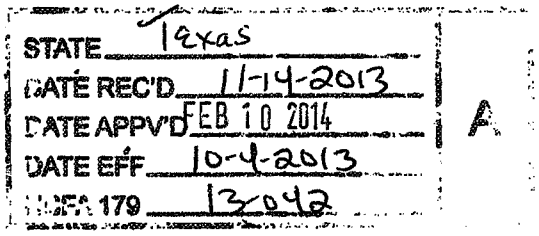
(B) Subtract each hospital's projected payment amount plus any previous payment amounts for the program year from subparagraph (A) of this paragraph from each hospital's interim hospital-specific limit to determine the maximum additional DSH allocation.

(C) Determine the non-federal share of funding and associated federal matching funds available for each rural public or rural public-financed hospital.

(D) Prior to processing any full or partial DSH payment that includes an additional allocation of DSH funds as described in this paragraph, HHSC will determine if such a payment would cause total DSH payments for the full or partial payment to exceed the available DSH funds for the payment as described in subsection (b)(2) of this section. If HHSC makes such a determination, it will reduce the DSH payment amounts rural public and rural public-financed hospitals are eligible to receive through the additional allocation as required to remain within the available DSH funds for the payment. This reduction will be applied proportionally to all additional allocations. HHSC will:

(i) determine remaining available funds by subtracting payment amounts for all DSH hospitals calculated in paragraphs (4) and (5) of this subsection from the amount in subsection (f)(2) of this section.

(ii) determine the total additional allocation supported by non-federal funds by summing the amounts supported by non-federal funding identified in subparagraph (C) of this paragraph.



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DSH Payment Calculation (continued)

(iii) determine an available proportion statistic by dividing the remaining available funds from clause (i) of this subparagraph by the total additional allocation supported by non-federal funds from clause (ii) of this subparagraph; and

(iv) multiply each non-federal funds supported payment from subparagraph (C) of this paragraph by the proportion statistic determined in clause (iii) of this subparagraph. The resulting product will be the additional allowable allocation for the payment.

(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 hospitals in the same category that are eligible for additional payments.

(8) The sum of the annual payment amounts for state-owned and non-state-owned IMDs are summed and compared to the federal IMD limit. If the sum of the annual payment amounts exceeds the federal IMD limit, the state-owned and non-state owned IMDs are reduced on a pro-rata basis so that the sum is equal to the federal IMD limit.

(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)
Recovery of DSH funds

(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)(2).

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