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State/Territory Name: Texas

State Plan Amendment (SPA) #: 13-36 NIRT

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

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

MAY 22 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 13-36

Dear Ms. Ghahremani:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 13-36. This amendment implements various changes to the inpatient hospital services reimbursement methodology, effective September 1, 2013.

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 13-36 is approved effective September 1, 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: **13-036**

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 1, 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:
42 CFR §440.10

7. FEDERAL BUDGET IMPACT: **SEE ATTACHMENT**
a. **FFY 2013** **($ 905,858)**
b. **FFY 2014** **($11,320,070)**
c. **FFY 2015** **($11,604,265)**

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

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: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

10. SUBJECT OF AMENDMENT:

The amendment modifies the children's hospital and rural hospital methodology to move from the TEFRA methodology to an SDA based methodology, adjusts the outlier payment methodology to more appropriately pay for outliers, and reduces outlier payments by 10 percent for certain provider groups. The amendment revises the definition of a rural hospital based on newer census information. Additionally, the amendment updates the payment method used for labor and delivery services at children's hospitals.

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

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

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Kay Ghahremani

14. TITLE:
State Medicaid Director

15. DATE SUBMITTED:
September 30, 2013

16. RETURN TO:

Kay Ghahremani
State Medicaid Director
Post Office Box 13247 MC: H-100
Austin, Texas 78711-5200

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 9-30-2013

18. DATE APPROVED: MAY 22 2014

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
SEP 01 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 13-036

Number of the Plan Section or Attachment	**Number of the Superseded Plan Section or Attachment**
Attachment 4.19-A	Attachment 4.19-A
Page 1a	Page 1a (TN 12-038)
Page 2	Page 2 (TN 12-038)
Page 3	Page 3 (TN 12-038)
Page 4	Page 4 (TN 12-038)
Page 5	Page 5 (TN 12-038)
Page 6	Page 6 (TN 12-038)
Page 7	Page 7 (TN 12-038)
Page 8	Page 8 (TN 12-038)
Page 8a	Page 8a (TN 12-038)
Page 8b	Page 8b (TN 12-038)
Page 8c	Page 8c (TN 12-038)
Page 8d	Page 8d (TN 12-038)
Page 8e	Page 8e (TN 12-038)
Page 8f	Page 8f (TN 12-038)
Page 8g	Page 8g (TN 12-038)
Page 8h	Page 8h (TN 12-038)
Page 8i	~~New Page~~ (TN 11-40)
Page 8j	New Page
Page 8k	New Page
Page 8l	New Page
Page 9	Page 9 (TN 11-040)
Page 9a	Page 9a (TN 11-040)
Deleted	Page 9b (TN 11-060)

STATE Texas
DATE REC'D 9-30-2013
DATE APPV'D MAY 22 2014
DATE EFF 9-1-2013
TN NO. 179 13-36

A

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – INPATIENT HOSPITAL SERVICES

(a) Introduction. The Texas Health and Human Services Commission (HHSC) uses the methodology described in this section to calculate reimbursement for a covered inpatient hospital service.

(b) Definitions.

(1) Adjudicated--The approval or denial of an inpatient hospital claim by HHSC.

(2) Add-on--An amount that is added to the base SDA to reflect high-cost functions and services or regional cost differences.

(3) Base standard dollar amount (base SDA)--A standardized payment amount calculated by HHSC, as described in subsection (d) of this section, for the costs incurred by prospectively-paid hospitals in Texas for furnishing covered inpatient hospital services.

(4) Base year--For the purpose of this section, the base year is a state fiscal year (September through August) to be determined by HHSC.

(5) Base year claims--All Medicaid traditional fee-for-service (FFS) and Primary Care Case Management (PCCM) inpatient hospital claims for reimbursement filed by a hospital that:

(A) had a date of admission occurring within the base year;

(B) were adjudicated and approved for payment during the base year and the six-month grace period that immediately followed the base year, except for such claims that had zero inpatient days;

(C) were not claims for patients who are covered by Medicare;

(D) were not Medicaid spend-down claims;

(E) were not claims associated with military hospitals, out-of-state hospitals, state owned teaching hospitals, and freestanding psychiatric hospitals.

(F) Individual sets of base year claims are compiled for children's hospitals, rural hospitals, and urban hospitals for the purposes of rate setting and rebasing.

(6) Base year cost per claim--The cost for a base year claim that would have been paid to a hospital if HHSC reimbursed the hospital under methods and procedures used in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), without the application of the TEFRA target cap for all hospitals except children's and state-owned teaching hospitals.

(7) Children's hospital--A Medicaid hospital designated by Medicare as a children's hospital.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – INPATIENT HOSPITAL SERVICES

(8) Cost outlier payment adjustment--A payment adjustment for a claim with extraordinarily high costs.

(9) Cost outlier threshold--One factor used in determining the cost outlier payment adjustment.

(10) Day outlier payment adjustment--A payment adjustment for a claim with an extended length of stay.

(11) Day outlier threshold--One factor used in determining the day outlier payment adjustment.

(12) Diagnosis-related group (DRG)--The classification of medical diagnoses as defined in the 3M™ All Patient Refined Diagnosis Related Group (APR-DRG) system or as otherwise specified by HHSC.

(13) Final settlement--Reconciliation of cost in the Medicare/Medicaid hospital fiscal year end cost report performed by HHSC within six months after HHSC receives the cost report audited by a Medicare intermediary or HHSC.

(14) Final standard dollar amount (final SDA)--The rate assigned to a hospital after HHSC applies the add-ons and other adjustments described in this section.

(15) Geographic wage add-on--An adjustment to a hospital's base SDA to reflect geographical differences in hospital wage levels. Hospital geographical areas correspond to the Core-Based Statistical Areas (CBSAs) established by the federal Office of Management and Budget in 2003.

(16) HHSC--The Texas Health and Human Services Commission or its designee.

(17) Impact file--The Inpatient Prospective Payment System (IPPS) Final Rule Impact File that contains data elements by provider used by the Centers for Medicare and Medicaid Services (CMS) in calculating Medicare rates and impacts. The impact file is publicly available on the CMS website.

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

(19) In-state children's hospital--A hospital located within Texas that is recognized by Medicare as a children's hospital and is exempted by Medicare from the Medicare prospective payment system.

(20) Interim payment--An initial payment made to a hospital that is later settled to Medicaid-allowable costs, for hospitals reimbursed under methods and procedures in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA).

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – INPATIENT HOSPITAL SERVICES

(21) Interim rate--The ratio of Medicaid allowed inpatient costs to Medicaid allowed inpatient charges filed on a hospital's Medicare/Medicaid cost report, expressed as a percentage. The interim rate established during a cost report settlement for an urban hospital or a rural hospital reimbursed under this section excludes the application of TEFRA target caps and the resulting incentive and penalty payments.

(22) Mean length of stay (MLOS)--One factor used in determining the payment amount calculated for each DRG; for each DRG, the average number of days that a patient stays in the hospital.

(23) Medical education add-on--An adjustment to the base SDA for an urban teaching hospital to reflect higher patient care costs relative to non-teaching urban hospitals.

(24) Military hospital--A hospital operated by the armed forces of the United States.

(25) New Hospital--A hospital that was enrolled as a Medicaid provider after the end of the base year and has no base year claims data.

(26) Out-of-state children's hospital--A hospital located outside of Texas that is recognized by Medicare as a children's hospital and is exempted by Medicare from the Medicare prospective payment system.

(27) Rebasing--Calculation of the base year cost per claim for each Medicaid inpatient hospital.

(28) Relative weight--The weighting factor HHSC assigns to a DRG representing the time and resources associated with providing services for that DRG.

(29) Rural hospitals--A hospital in a county with 60,000 or fewer persons based on the 2010 decennial census, a hospital designated by Medicare as a Critical Access Hospital (CAH), a Sole Community Hospital (SCH), or a Rural Referral Center (RRC).

(30) State-owned teaching hospital--The following hospitals: University of Texas Medical Branch (UTMB); University of Texas Health Center Tyler; and M.D. Anderson Hospital.

(31) Teaching hospital--A hospital for which CMS has calculated and assigned a percentage Medicare education adjustment factor under 42 CFR §412.105.

(32) Teaching medical education add-on--An adjustment to the base SDA for a children's teaching hospital with a program approved by the Accreditation Council for Graduate Medical Education (ACGME) to reflect higher patient care costs relative to non-teaching children's hospitals.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – INPATIENT HOSPITAL SERVICES

(33) TEFRA target cap--A limit set under the Social Security Act §1886(b) (42 U.S.C. §1395ww(b)) and applied to a hospital's cost settlement under methods and procedures in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). TEFRA target cap is not applied to services provided to patients under age 21, and incentive and penalty payments associated with this limit are not applicable to those services.

(34) Tentative settlement--Reconciliation of cost in the Medicare/Medicaid hospital fiscal year-end cost report performed by HHSC within six months after HHSC receives an acceptable cost report filed by a hospital.

(35) Texas provider identifier--A unique number assigned to a provider of Medicaid services in Texas.

(36) Trauma add-on--An adjustment to the base SDA for a trauma hospital to reflect the higher costs of obtaining and maintaining a trauma facility designation, as well as the direct costs of providing trauma services, relative to non-trauma hospitals or to hospitals with lower trauma facility designations.

(37) Trauma hospital--An inpatient hospital that meets the Texas Department of State Health Services criteria for a Level I, II, III, or IV trauma facility designation under 25 Texas Administrative Code §157.125 (relating to Requirements for Trauma Facility Designation).

(38) Universal mean--Average base year cost per claim for all urban hospitals.

(39) Urban hospital--Hospital located in a metropolitan statistical area and not fitting the definition of rural hospitals, children's hospitals, state-owned teaching hospitals, or freestanding psychiatric hospitals.

(c) Base urban and children's hospital standard dollar amount (SDA) calculations. HHSC will use the methodologies described in this subsection to determine two separate average statewide base SDAs: one for children's hospitals and one for urban hospitals. For each category of hospital:

(1) HHSC calculates the average base year cost per claim as follows:

(A) Use the sum of the base year costs per claim for each hospital.

(B) Sum the amount for all hospitals' base year costs from subparagraph (A) of this paragraph.

(C) For children's hospitals subtract an amount equal to the estimated outlier payment amount for the base year claims for all children's hospitals from subparagraph (B) of this paragraph.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – INPATIENT HOSPITAL SERVICES

(D) To derive the average base year cost per claim:

(i) for urban hospitals, divide the result from subparagraph (B) of this paragraph by the total number of base year claims; and

(ii) for children's hospitals, divide the result from subparagraph (C) of this paragraph by the total number of base year claims.

(E) The result from subparagraph (D)(i) of this paragraph is the universal mean that is used in calculations described in subsections (g) and (h) of this section.

(2) From the amount determined in paragraph (1)(B) of this subsection for urban hospitals and paragraph (1)(C) of this subsection for children's hospitals, HHSC sets aside an amount to recognize high-cost hospital functions, services and regional wage differences. The amount set aside will be used in the calculation of the add-ons in subsection (d). In determining the amount to set aside, HHSC considers factors including other funding available to reimburse high-cost hospital functions and services, available data sources, historical costs, Medicare practices, and feedback from hospital industry experts .

(A) The costs remaining after HHSC sets aside the amount for high-cost hospital functions and services will be used to determine the base SDA.

(B) The costs HHSC sets aside will determine the funds available for distribution to hospitals that are eligible for one or more add-ons as described in subsection (d) of this section.

(3) HHSC divides the amount in paragraph (2)(A) of this subsection by the total number of base year claims to derive the base SDA.

(d) Add-ons.

(1) A children's hospital may receive increases to the base SDA for any of the following:

(A) Geographic wage add-on, as described in paragraph (4) of this subsection.

(i) For claims with dates of admission beginning September 1, 2013, and continuing until the next rebasing, the geographic wage add-on for children's hospitals will be calculated based on the impact file in effect on September 1, 2011.

(ii) Subsequent add-ons will be based on the impact file available at the time of rebasing.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – INPATIENT HOSPITAL SERVICES

(B) Teaching medical education add-on, as described in paragraph (5) of this subsection.

(2) An urban hospital may receive increases to the base SDA for any of the following:

(A) Geographic wage add-on, as described in paragraph (4) of this subsection.

(B) Medical education add-on, as described in paragraph (6) of this subsection.

(C) Trauma add-on, as described in paragraph (7) of this subsection.

(3) Add-on amounts will be determined or adjusted based on the following:

(A) Impact files.

(i) HHSC will use the impact file in effect at the last rebasing to calculate add-ons for new hospitals, except as otherwise specified in this section; and

(ii) HHSC will use the most recent finalized impact file from the current Hospital Inpatient Prospective Payment System (PPS) final rule available at the time of rebasing to calculate add-ons.

(B) If a hospital becomes eligible for the geographic wage reclassification under Medicare during the fiscal year, the hospital will become eligible for the adjustment upon the next rebasing.

(C) If a hospital becomes eligible for the teaching medical education add-on, medical education add-on, or trauma add-on during the fiscal year, the hospital will receive an increased final SDA to include these newly eligible add-ons, effective for claims that have a date of admission occurring on or after the first day of the next state fiscal year.

(D) If an eligible children's hospital is new to the Medicaid program and a cost report is not available, the teaching medical education add-on will be calculated at the beginning of the state fiscal year after a cost report is received.

(4) Geographic wage add-on.

(A) Wage index. To determine a children's or urban hospital's geographic wage add-on, HHSC first calculates a wage index for Texas as follows:

(i) HHSC identifies the Medicare wage index factor for each Core Based Statistical Area (CBSA) in Texas.

(ii) HHSC identifies the lowest Medicare wage index factor in Texas.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – INPATIENT HOSPITAL SERVICES

(iii) HHSC divides the Medicare wage index factor for each CBSA by the lowest Medicare wage index factor identified in clause (ii) of this subparagraph and subtracts one from each resulting quotient to arrive at a percentage.

(iv) HHSC uses the result of the calculations in clause (iii) of this subparagraph to calculate each CBSA's add-on amount described in subparagraph (C) of this paragraph.

(B) County assignment. HHSC will initially assign a hospital to a CBSA based on the county in which the hospital is located. A hospital that has been approved for geographic reclassification under Medicare may request that HHSC recognize its Medicare CBSA reclassification, under the process described in paragraph (8) of this subsection.

(C) Add-on amount.

(i) HHSC calculates 62 percent of the base SDA to derive the labor-related portion of that rate, consistent with the Medicare labor-related percentage.

(ii) To determine the geographic wage add-on amount for each CBSA, HHSC multiplies the wage index factor determined in subparagraph (A)(iv) of this paragraph for that CBSA by the percentage labor share of the base SDA calculated in clause (i) of this subparagraph.

(5) Teaching medical education add-on.

(A) Eligibility. A teaching hospital that is a children's hospital is eligible for the teaching medical education add-on. Each children's hospital is required to confirm, under the process described in paragraph (8) of this subsection, that HHSC's determination of the hospital's eligibility for the add-on is correct.

(B) Add-on amount. HHSC calculates the teaching medical education add-on amounts as follows:

(i) For each children's hospital, identify the total hospital medical education cost from each hospital cost report or reports that cross over the base year.

(ii) For each children's hospital, sum the amounts identified in clause (i) of this subparagraph to calculate the total medical education cost.

(iii) For each children's hospital, calculate the average medical education cost by dividing the amount from clause (ii) of this subparagraph by the number of cost reports that cross over the base year.

(iv) Sum the average medical education cost per hospital to determine a total average medical education cost for all hospitals.

(v) For each children's hospital, divide the average medical education cost for the hospital from clause (iii) of this subparagraph by the total average medical education cost for all hospitals from clause (iv) of this subparagraph to calculate a percentage for the hospital.

(vi) Divide the total average medical education cost for all hospitals from clause (iv) of this subparagraph by the total base year cost for all children's hospitals from subsection (c)(1)(B) of this section to determine the overall teaching percentage of Medicaid cost.

(vii) For each children's hospital, multiply the percentage from clause (v) of this subparagraph by the percentage from clause (vi) of this subparagraph to determine the teaching percentage for the hospital.

(viii) For each children's hospital, multiply the hospital's teaching percentage by the base SDA amount to determine the teaching medical education add on amount.

(6) Medical education add-on.

(A) Eligibility. A teaching hospital that is an urban hospital is eligible for the medical education add-on. Each hospital is required to confirm, under the process described in paragraph (8) of this subsection, that HHSC's determination of the hospital's eligibility and Medicare education adjustment factor for the add-on is correct.

(B) Add-on amount. HHSC multiplies the base SDA by the hospital's Medicare education adjustment factor to determine the hospital's medical education add-on amount.

(7) Trauma add-on.

(A) Eligibility.

(i) To be eligible for the trauma add-on, a hospital must be designated as a trauma hospital by the Texas Department of State Health Services and be eligible to receive an allocation from the trauma facilities and emergency medical services account under Chapter 780, Health and Safety Code.

(ii) HHSC initially uses the trauma level designation associated with the physical address of a hospital's TPI. A hospital may request that HHSC, under the process described in paragraph (8) of this subsection, use a higher trauma level designation associated with a physical address other than the hospital's TPI address.

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(B) Add-on amount. To determine the trauma add-on amount, HHSC multiplies the base SDA:

(i) by 12.8 percent for hospitals with Level 1 trauma designation;

(ii) by 8.2 percent for hospitals with Level 2 trauma designation;

(iii) by 1.4 percent for hospitals with Level 3 trauma designation; or

(iv) by 0.9 percent for hospitals with Level 4 trauma designation.

(C) Reconciliation with other reimbursement for uncompensated trauma care. Subject to the General Appropriations Act and other applicable law:

(i) If a hospital's allocation from the trauma facilities and emergency medical services account administered under Chapter 780, Health and Safety Code, is greater than the total trauma add-on amount estimated to be paid to the hospital under this section during the state fiscal year, the Department of State Health Services will pay the hospital the difference between the two amounts at the time funds are disbursed from that account to eligible trauma hospitals.

(ii) If a hospital's allocation from the trauma facilities and emergency medical services account is less than the total trauma add-on amount estimated to be paid to the hospital under this section during the state fiscal year, the hospital will not receive a payment from the trauma facilities and emergency medical services account.

(8) Add-on status verification.

(A) Notification. HHSC will determine a hospital's initial add-on status by reference to the impact file and the Texas Department of State Health Services' list of trauma-designated hospitals. HHSC will notify the hospital of the CBSA to which the hospital is assigned, the Medicare education adjustment factor assigned to the hospital for urban hospitals, the trauma level designation assigned to the hospital, the Medicare teaching hospital designation for children's hospitals, as applicable and any other related information determined relevant by HHSC.

State: Texas
Date Received: 9/30/13
Date Approved: MAY 22 2014
Date Effective: 9/1/13
Transmittal Number: 13-36

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(B) HHSC will calculate a hospital's final SDA using the add-on status initially determined by HHSC unless, within 14 calendar days after the date of the notification, HHSC receives notification, in writing by regular mail, hand delivery or special mail delivery, from the hospital (in a format determined by HHSC) that any add-on status determined by HHSC is incorrect and:

(i) the hospital provides documentation of its eligibility for a different trauma designation, medical education percentage, or teaching hospital designation; or

(ii) the hospital provides documentation that it is approved by Medicare for reclassification to a different CBSA.

(C) If a hospital fails to notify HHSC within 14 calendar days after the date of the notification that the add-on status as initially determined by HHSC includes one or more add-ons for which the hospital is not eligible, resulting in an overpayment, HHSC will recoup such overpayment and will prospectively reduce the SDA accordingly.

(e) Final urban and children's hospital SDA calculations.

(1) HHSC calculates an urban hospital's final SDA as follows:

(A) Add all add-on amounts for which the hospital is eligible to the base SDA.

(B) Multiply the SDA determined in subparagraph (A) of this paragraph by the hospital's total relative weight of base year claims as calculated in subsection (g)(1) of this section.

(C) Sum the amount calculated in subparagraph (B) of this paragraph for all urban hospitals.

(D) Divide the total funds appropriated for reimbursing inpatient urban hospital services under this section by the amount determined in subparagraph (C) of this paragraph.

(E) Multiply the SDA determined for each hospital in subparagraph (A) of this paragraph by the percentage determined in subparagraph (D) of this paragraph.

(F) For new urban hospitals for which HHSC has no base year claim data, the final SDA is the base SDA plus any add-ons for which the hospital is eligible, multiplied by the percentage determined in subparagraph (D) of this paragraph.

(2) HHSC calculates a children's hospital's final SDA as follows:

(A) Add all add-on amounts for which the hospital is eligible to the base SDA.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – INPATIENT HOSPITAL SERVICES

(B) For labor and delivery services provided to adults age eighteen or greater in a children's hospital, the final SDA is equal to the base SDA for urban hospitals without add-ons, calculated as described in subsection (c)(3) of this section plus the urban hospital wage add-on for an urban hospital located in the same CBSA as the children's hospital providing the service.

(C) For new children's hospitals that are not teaching hospitals for which HHSC has no base year claim data, the final SDA is the base SDA plus the hospital's geographic wage add-on. The SDA will be inflated from the base year to the current period at the time of enrollment or to state fiscal year 2015, whichever is earlier.

(D) For new children's hospitals that qualify for the teaching medical education add-on described in subsection (b)(31) of this section for which HHSC has no base year claim data, the final SDA is calculated based on one of the following options until rebasing is performed with base year claim data for the hospital. A new children's hospital must notify the HHSC Rate Analysis Department of its selected option within 60 days from the date the hospital is notified of its provider activation by HHSC's fiscal intermediary. If notice of the option is not received, HHSC will assign the hospital the SDA calculated as described in clause (i) of this subparagraph. The SDA calculated based on the selected option will be effective retroactive to the first day of the provider's enrollment.

(i) Children's hospital base SDA plus the applicable geographic wage add-on and the minimum teaching add-on for existing children's hospitals. No settlement of costs is required for services reimbursed under this option. The SDA will be in effective for the hospital for three years or until the next rebasing when a new SDA will be determined. The SDA will be inflated from the base year to the current period at the time of enrollment or to state fiscal year 2015, whichever is earlier.

(ii) Children's base SDA plus the applicable geographic wage add-on and the maximum teaching add-on for existing children's hospitals. A cost settlement is required for services reimbursed under this option. The SDA will be in effect for the hospital for three years or until the next rebasing when a new SDA will be determined. The SDA will be inflated from the base year to the current period at the time of enrollment or to state fiscal year 2015, whichever is earlier.

(E) For state fiscal year 2014 only, HHSC will calculate a blended SDA for children's hospitals, other than those described in subparagraphs (C) and (D) of this paragraph, as follows:

(i) Calculate a full-cost SDA by dividing the hospital's total base year cost determined in subsection (c)(1)(A) of this section by the number of claims in the base year;

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – INPATIENT HOSPITAL SERVICES

(ii) Multiply the result of clause (i) of this subparagraph by 0.50;

(iii) Multiply the hospital's final base SDA from subparagraph (A) of this paragraph by 0.50;

(iv) Sum the results of the calculations described in clauses (ii) and (iii) of this subparagraph.

(v) The resulting blended SDA determined in clause (iv) of this subparagraph will be adjusted by the inflation update factor from the base year to state fiscal year 2014.

(F) For state fiscal year 2015, the final SDA determined in subparagraphs (A), (C) and (D) of this paragraph will be adjusted by the inflation update factor from the base year to state fiscal year 2015. This SDA will remain in effect until the next rebasing.

(3) For military and out-of-state hospitals, the final SDA is the urban hospital base SDA multiplied by the percentage determined in paragraph (1)(D) of this subsection.

(f) Final rural hospital SDA calculation.

(1) HHSC calculates a rural hospital's final SDA as follows:

(A) Calculate a hospital-specific full-cost SDA by dividing each hospital's base year cost, calculated as described in subsection (c)(1)(A) of this section, by the number of claims in the base year;

(B) Adjust the result from subparagraph (A) of this paragraph by multiplying the specific-specific full-cost SDA by the inflation update factor to obtain an adjusted hospital-specific SDA;

(C) Calculate an SDA floor based on 1.5 standard deviations below the average adjusted hospital-specific SDA from subparagraph (B) of this paragraph for all rural hospitals with more than 50 claims as calculated in subparagraph (B) of this paragraph;

(D) Calculate an SDA ceiling based on 2.0 standard deviations above the average adjusted hospital-specific SDA from subparagraph (B) of this paragraph for all rural hospitals with more than 50 claims as calculated in subparagraph (B) of this paragraph;

(E) Compare the adjusted hospital-specific SDA for each hospital from subparagraph (B) of this paragraph to the SDA floor from subparagraph (C) of this paragraph. If the adjusted hospital-specific SDA is less than the SDA floor, the hospital is assigned the SDA floor amount as the final SDA;

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – INPATIENT HOSPITAL SERVICES

(F) Compare the adjusted hospital-specific SDA for each hospital from subparagraph (B) of this paragraph to the SDA ceiling from subparagraph (D) of this paragraph. If the adjusted hospital-specific SDA is more than the SDA ceiling, the hospital is assigned the SDA ceiling amount as the final SDA;

(G) Assign the adjusted hospital-specific SDA as the final SDA to each hospital not described in subparagraphs (E) and (F) of this paragraph.

(2) HHSC calculates a new rural hospital's final SDA as follows:

(A) For new rural hospitals for which HHSC has no base year claim data, the final SDA is the mean rural SDA, calculated by dividing the sum of the SDA amounts from paragraph (1) of this subsection by the number of hospitals in the group.

(B) The mean rural SDA remains in effect until the next rebasing using the steps outlined in paragraph (1)(A) - (G) of this subsection, using the SDA floor and SDA ceiling in effect for the fiscal year.

(3) For hospitals in Rockwall County:

(A) For state fiscal year 2014 only, for each hospital, HHSC will calculate a blended SDA as follows:

(i) Calculate a final SDA as described in paragraph (1) of this subsection;

(ii) Multiply the result of clause (i) of this subparagraph by 0.67;

(iii) Calculate a final urban SDA as described in subsection (e)(1) of this section.

(iv) Multiply the hospital's final urban SDA from clause (iii) of this subparagraph by 0.33;

(v) Sum the results of the calculations described in clauses (ii) and (iv) of this subparagraph.

(B) For state fiscal year 2015 only, for each hospital, HHSC will calculate a blended SDA as follows:

(i) Calculate a final SDA as described in paragraph (1) of this subsection;

(ii) Multiply the result of clause (i) of this subparagraph by 0.33;

(iii) Calculate a final urban SDA as described in subsection (e)(1) of this section.

(iv) Multiply the hospital's final urban SDA from clause (iii) of this subparagraph by 0.67;

(v) Sum the results of the calculations described in clauses (ii) and (iv) of this subparagraph.

(C) For state fiscal year 2016 and thereafter, hospitals in Rockwall County will be classified as urban hospitals and will receive the final SDA as calculated in subsection (e)(1) of this section.

(g) DRG statistical calculations. HHSC recalibrates the relative weights, MLOS and day outlier threshold whenever the base SDAs for urban hospitals are recalculated. The relative weights, MLOS, and day outlier thresholds are calculated using data from urban hospitals and apply to all hospitals. The relative weights that were implemented for urban hospitals on September 1, 2012, apply to all hospitals until the next rebasing.

(1) Recalibration of relative weights. HHSC calculates a relative weight for each DRG as follows:

(A) Base year claims are grouped by DRG

(B) For each DRG, HHSC:

(i) sums the base year costs per claim as determined in subsection (c) of this section;

(ii) divides the result in clause (i) of this subparagraph by the number of claims in the DRG; and

(iii) divides the result in clause (ii) of this subparagraph by the universal mean, resulting in the relative weight for the DRG

(2) Recalibration of the MLOS. HHSC calculates the MLOS for each DRG as follows:

(A) Base year claims are grouped by DRG

(B) For each DRG, HHSC:

(i) sums the number of days billed for all base year claims;

(ii) divides the result in clause (i) of this subparagraph by the number of claims in the DRG, resulting in the MLOS for the DRG.

(3) Recalibration of day outlier thresholds. HHSC calculates a day outlier threshold for each DRG as follows

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(A) Calculate for all claims the standard deviations from the MLOS in paragraph (2) of this subsection.

(B) Remove each claim with a length of stay (number of days billed by a hospital) greater than or equal to three standard deviations above or below the MLOS. The remaining claims are those with a length of stay less than three standard deviations above or below the MLOS.

(C) Sum the number of days billed by all hospitals for a DRG for the remaining claims in subparagraph (B) of this paragraph.

(D) Divide the result in subparagraph (C) of this paragraph by the number of remaining claims in subparagraph (B) of this paragraph

(E) Calculate one standard deviation for the result in subparagraph (D) of this paragraph.

(F) Multiply the result in subparagraph (E) of this paragraph by two and add that to the result in subparagraph (D) of this paragraph, resulting in the day outlier threshold for the DRG.

(4) If a DRG has fewer than five base year claims, HHSC will use National Claim Statistics to assign:

(A) a national relative weight recalibrated to a relative weight calculated in paragraph (1) of this subsection; and

(B) an MLOS and a day outlier as described in paragraphs (2) and (3) of this subsection

(h) Reimbursements

(1) Calculating the payment amount. HHSC reimburses a hospital a prospective payment for covered inpatient hospital services by multiplying the hospital's final SDA as calculated in subsection (e) or (f) of this section as appropriate by the relative weight for the DRG assigned to the adjudicated claim. The resulting amount is the payment amount to the hospital

(2) The prospective payment as described in paragraph (1) of this subsection is considered full payment for covered inpatient hospital services. A hospital's request for payment in an amount higher than the prospective payment will be denied

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(3) Day and cost outlier adjustments. HHSC pays a day outlier or a cost outlier for medically necessary inpatient services provided to clients under age 21 in all Medicaid participating hospitals that are reimbursed under the prospective payment system. If a patient age 20 is admitted to and remains in a hospital past his or her 21st birthday, inpatient days and hospital charges after the patient reaches age 21 are included in calculating the amount of any day outlier or cost outlier payment adjustment

(A) Day outlier payment adjustment. HHSC calculates a day outlier payment adjustment for each claim as follows:

(i) Determine whether the number of medically necessary days allowed for a claim exceeds:

(I) the MLOS by more than two days; and

(II) the DRG day outlier threshold as calculated in subsection (g)(3) of this section.

(ii) If clause (i) of this subparagraph is true, subtract the DRG day outlier threshold from the number of medically necessary days allowed for the claim

(iii) Multiply the DRG relative weight by the final SDA

(iv) Divide the result in clause (iii) of this subparagraph by the DRG MLOS described in subsection (g)(2) of this section, to arrive at the DRG per diem amount

(v) Multiply the number of days in clause (ii) of this subparagraph by the result in clause (iv) of this subparagraph.

(vi) Multiply the result in clause (v) of this subparagraph by 60 percent.

(vii) Multiply the allowed charges by the current interim rate to determine the cost.

(viii) Subtract the DRG payment amount calculated in clause (iii) of this subparagraph from the cost calculated in clause (vii) of this subparagraph.

(ix) The day outlier amount is the lesser of the amount in clause (vi) of this subparagraph or the amount in clause (viii) of this subparagraph.

(x) For urban and rural hospitals, multiply the amount in clause (ix) of this subparagraph by 90 percent to determine the final day outlier amount. For children's hospitals the amount in clause (ix) of this subparagraph is the final day outlier amount.

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(B) Cost outlier payment adjustment. HHSC makes a cost outlier payment adjustment for an extraordinarily high-cost claim as follows:

(i) To establish a cost outlier, the cost outlier threshold must be determined by first selecting the lesser of the universal mean of base year claims multiplied by 11.14 or the hospital's final SDA multiplied by 11.14.

(ii) Multiply the full DRG prospective payment by 1.5.

(iii) The cost outlier threshold is the greater of clause (i) or (ii) of this subparagraph.

(iv) Subtract the cost outlier threshold from the amount of reimbursement for the claim established under cost reimbursement principles described in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA).

(v) Multiply the result in clause (iv) of this subparagraph by 60 percent to determine the amount of the cost outlier payment

(vi) For urban and rural hospitals, multiply the amount in clause (v) of this subparagraph by 90 percent to determine the final cost outlier amount. For children's hospitals the amount in clause (v) of this subparagraph is the final cost outlier amount.

(C) Final outlier determination:

(i) If the amount calculated in subparagraph (A)(ix) of this paragraph is greater than zero and the amount calculated in subparagraph (B)(vi) of this paragraph is greater than zero, HHSC pays the higher of the two amounts.

(ii) If the amount calculated in subparagraph (A)(ix) of this paragraph is greater than zero and the amount calculated in subparagraph (B)(vi) of this paragraph is less than or equal to zero, HHSC pays the day outlier amount.

(iii) If the amount calculated in subparagraph (B)(vi) of this paragraph is greater than zero and the amount calculated in subparagraph (A)(ix) of this paragraph is less than or equal to zero, HHSC pays the cost outlier amount.

(iv) If the amount calculated in subparagraph (A)(ix) of this paragraph and the amount calculated in subparagraph (B)(vi) of this paragraph are both less than or equal to zero HHSC will not pay an outlier for the admission.

(D) If the hospital claim resulted in a downgrade of the DRG related to reimbursement denials or reductions for preventable adverse events, the outlier payment will be determined by the lesser of the calculated outlier payment for the non-downgraded DRG or the downgraded DRG.

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(4) A hospital may submit a claim to HHSC before a patient is discharged, but only the first claim for that patient will be reimbursed the prospective payment described in paragraph (1) of this subsection. Subsequent claims for that stay are paid zero dollars. When the patient is discharged and the hospital submits a final claim to ensure accurate calculation for potential outlier payments for clients younger than age 21, HHSC recoups the first prospective payment and issues a final payment in accordance with paragraphs (1) and (3) of this subsection.

(5) Patient transfers and split billing. If a patient is transferred, HHSC establishes payment amounts as specified in subparagraphs (A) - (D) of this paragraph. HHSC manually reviews transfers for medical necessity and payment.

(A) If the patient is transferred from a hospital to a nursing facility, HHSC pays the transferring hospital the total payment amount of the patient's DRG.

(B) If the patient is transferred from one hospital (transferring hospital) to another hospital (discharging hospital), HHSC pays the discharging hospital the total payment amount of the patient's DRG. HHSC calculates a DRG per diem and a payment amount for the transferring hospital as follows:

(i) Multiply the DRG relative weight by the final SDA

(ii) Divide the result in clause (i) of this subparagraph by the DRG MLOS described in subsection (g)(2) of this section, to arrive at the DRG per diem amount.

(iii) To arrive at the transferring hospital's payment amount:

(I) for a patient age 21 or older, multiply the result in clause (ii) of this subparagraph by the lesser of the DRG MLOS, the transferring hospital's number of medically necessary days allowed for the claim, or 30 days; or

(II) for a patient under age 21, multiply the result in clause (ii) of this subparagraph by the lesser of the DRG MLOS or the transferring hospital's number of medically necessary days allowed for the claim.

(C) HHSC makes payments to multiple hospitals transferring the same patient by applying the per diem formula in subparagraph (B) of this paragraph to all the transferring hospitals and the total DRG payment amount to the discharging hospital.

(D) HHSC performs a post-payment review to determine if the hospital that provided the most significant amount of care received the total DRG payment. If the review reveals that the hospital that provided the most significant amount of care did not receive the total DRG payment, an adjustment is initiated to reverse the payment amounts. The transferring hospital is paid the total DRG payment amount and the discharging hospital is paid the DRG per diem

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(i) Cost reports. Each hospital must submit an initial cost report at periodic intervals as prescribed by Medicare or as otherwise prescribed by HHSC.

(1) Each hospital must send a copy of all cost reports audited and amended by a Medicare intermediary to HHSC within 30 days after the hospital's receipt of the cost report. Failure to submit copies or respond to inquiries on the status of the Medicare cost report will result in provider vendor hold.

(2) HHSC uses data from these reports in rebasing rate years to recalculate base SDAs, to calculate interim rates and to complete cost settlements.

(j) Cost Settlement.

(1) The cost settlement process is limited by the TEFRA target cap set pursuant to the Social Security Act §1886(b) (42 U.S.C. §1395ww(b)) for children's and state owned teaching hospitals.

(2) Notwithstanding the process described in paragraph (1) of this subsection, HHSC uses each hospital's final audited cost report, which covers a fiscal year ending during a base year period, for calculating the TEFRA target cap for a hospital.

(3) HHSC may select a new base year period for calculating the TEFRA target cap at least every three years.

(4) HHSC increases a hospital's TEFRA target cap in years in which the target cap is not reset under this paragraph, by multiplying the hospital's target cap by the CMS Prospective Payment System Hospital Market Basket Index adjusted to the hospital's fiscal year.

(5) For a new children's hospital, the base year for calculating the TEFRA target cap is the hospital's first full 12-month cost reporting period occurring after the date the hospital is designated by Medicare as a children's hospital. For each cost reporting period after the hospital's base year, an increase in the TEFRA target cap will be applied as described in paragraph (4) of this subsection, until the TEFRA target cap is recalculated as described in paragraph (3) of this subsection.

(6) After a Medicaid participating hospital is designated by Medicare as a children's hospital, the hospital must submit written notification to HHSC's provider enrollment contact, including documents verifying its status as a Medicare children's hospital. Upon receipt of the written notification from the hospital, HHSC will convert the hospital to the reimbursement methodology described in this subsection retroactive to the effective date of designation by Medicare.

(k) Out-of-state children's hospitals. HHSC calculates the prospective payment rate for an out-of-state children's hospital as follows:

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(1) HHSC determines the overall average cost per discharge for all in-state children's hospitals by:

(A) Summing the Medicaid allowed cost from tentative or final cost report settlements for the base year; and

(B) Dividing the result in subparagraph (A) of this paragraph by the number of in-state children's hospitals' base year claims described in subsection (c)(1)(D)(ii) of this section.

(2) HHSC determines the average relative weight for all of in-state children's hospitals' base year claims described in subsection (c)(1)(D)(ii) of this section by:

(A) Assigning a relative weight to each claim pursuant to subsection (g)(1)(B)(iii) of this section;

(B) Summing the relative weights for all claims; and

(C) Dividing by the number of claims.

(3) The result in paragraph (1) of this subsection is divided by the result in paragraph (2) of this subsection to arrive at the adjusted cost per discharge.

(4) The adjusted cost per discharge in paragraph (3) of this subsection is the payment rate used for payment of claims.

(5) HHSC reimburses each out-of-state children's hospital a prospective payment for covered inpatient hospital services. The payment amount is determined by multiplying the result in paragraph (4) of this subsection by the relative weight for the Diagnosis Related Group (DRG) assigned to the adjudicated claim.

(l) Merged hospitals.

(1) When two or more Medicaid participating hospitals merge to become one participating provider and the participating provider is recognized by Medicare, the participating provider must submit written notification to HHSC's provider enrollment contact, including documents verifying the merger status with Medicare.

(2) HHSC will assign to the merged entity the final SDA assigned to the hospital associated with the surviving TPI and will reprocess all claims for the merged entity back to the date of the merger or the first day of the fiscal year, whichever is later.

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(3) HHSC will not recalculate the final SDA of a hospital acquired in an acquisition or buyout unless the acquisition or buyout resulted in the purchased or acquired hospital becoming part of another Medicaid participating provider. HHSC will continue to reimburse the acquired hospital based on the final SDA assigned before the acquisition or buyout.

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(m) State-Owned Teaching Hospital Reimbursement Methodology.

(1) For cost reporting periods beginning on or after September 1, 2008, HHSC or its designee reimburses state-owned teaching hospitals under methods and procedures described in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA).

(2) For dates of admission on or after September 1, 2003, state-owned teaching hospitals with allowable direct graduate medical education (DGME) costs will receive a pro rata share of their annual DGME cost based on the availability of appropriated funds. DGME expenses are not considered costs associated with inpatient hospital services and are not settled to cost.

(3) Interim payments are determined by multiplying a hospital's charges allowed under Medicaid by the interim rate effective on the date of admission derived from the hospital's most recent Medicaid cost report settlement, whether tentative or final.

(4) Interim payments are subject to settlement at both tentative and final audit of a hospital's cost report.

(5) Cost Settlement.

(A) The cost settlement process is limited by the TEFRA target cap set pursuant to the Social Security Act §1886(b) (42 U.S.C. §1395ww(b)).

(B) Notwithstanding the process in (1), HHSC or its designee uses each hospital's final audited cost report, which covers a fiscal year ending during a base year period, for calculating the TEFRA target cap for each hospital.

(C) HHSC or its designee selects a new base year period for calculating the TEFRA target cap at least every three years.

(D) HHSC or its designee increases a hospital's TEFRA target cap in years in which the target cap is not reset under this paragraph, by multiplying the target cap by the CMS Prospective Payment System Hospital Market Basket Index adjusted to the hospital's fiscal year.

(n) – (x) Intentionally left blank.

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